CALIFORNIA ACCOUNTABLE COMMUNITIES FOR HEALTH INITIATIVE

CACHI

...The Next Generation of Health System Transformation

TRANSFORMATION IN ACTION:

How Accountable Communities for Health Promote Collaboration, Systems Change and Health Equity

CACHI's 2017-2022 Evaluation Report | Authored By:

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The California Accountable Communities for Health Initiative (CACHI) envisions ACHs as strategies for cross-sector and community collaboration in service of better health and health equity. Launched in 2016 with investment from multiple philanthropies, CACHI supported thirteen communities across the state to establish ACHs and address community health priorities for a period of up to five and a half years.

The original call to create ACHs in California came from the state Health Care Innovation Plan created as part of a State Innovation Model grant from the Centers for Medicare and Medicaid Innovation (CMMI). CACHI built on federal models like Accountable Care Organizations (ACOs), but with a greater focus on "health, wellness, equity, and prevention—not just care" (CACHI Request for Proposals, 2016) and on entire communities or neighborhoods rather than a specific patient or health plan enrollee population.

ABOUT THE MODEL

Conceptually, the CACHI model centers around equity and a Portfolio of Interventions (POI), a set of mutually supportive interventions that address a particular issue or condition. A backbone agency, cross-sector partnerships and leadership, and governance arrangements all serve as foundational infrastructure for the ACH to work towards a shared vision. Robust community engagement shapes the ACH vision as well as the design and implementation of the POI, and community members are among the groups to which CACHI ACHs are accountable.

Finally, the model specifies that ACHs use data to set

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About the California Accountable Communities for Health Initiative (CACHI)

CACHI is a public-private collaboration with support from the California Department of Public Health, The California Endowment, Blue Shield of California Foundation, The California Wellness Foundation and others (see *Acknowledgements* on Page 91).

CACHI was established to lead efforts to modernize our health system and build a healthier California. We aim to transform the health of entire communities, not just individual patients.

By bringing together valuable community institutions—hospitals, public health organizations, schools, public safety agencies, parks, and local businesses—along with residents, CACHI is creating a new vision for our health system: a health system capable of fundamentally changing health outcomes by aligning interventions for maximum impact, promoting prevention, and organizing resources to focus on the most effective strategies.

Through this effort, we can move closer to making health equity among all community members a reality in California.

direction and monitor and communicate progress toward their goals, and Wellness Funds are established to attract resources and sustain their work for the long term. The CACHI model is unique but shares some elements of other multi-sector frameworks (e.g., Collective Impact (Kania & Kramer, 2011) and Aligning Systems for Health (2021)).

ABOUT THE SITES

Thirteen ACHs from across California participated in CACHI from 2017 to early 2022. Each site had a specific geographic focus, ranging in size from an entire county (e.g., Imperial County) to a neighborhood or part of a city (e.g., South Stockton). As part of their CACHI funding, each ACH selected a community health priority or set of priorities around which to focus their POI such as cardiovascular disease, nutrition, or community violence and trauma.

OVERALL VALUE OF THE ACH

California ACHs are in an ideal position to align cross-sector strategies and improve community health by creating bridges among county agencies, health care systems, health plans and communities. The ACH structure enables sectors, organizations, and residents to coalesce and align to address and transform the socio economic, environmental, and various structural conditions that impact the health and well-being of communities. The work ACHs do around convening partners, creating cross-sector workgroups, and partnering with existing community initiatives creates the conditions for greater impact on community health than one organization could have on their own. Communities can leverage the ACH infrastructure to demonstrate to funders that the community is aligned in achieving certain goals, thereby increasing funder confidence in their investments.

Finally, many California ACHs have identified ways to incorporate equity and the community voice, not only by including community members in meetings and offering translation services, but also by addressing diversity across all aspects of the governance structure to ensure ACH activities reflect community needs and priorities. The longer ACHs work within their communities, the greater their capacity to provide and demonstrate value to organizational partners and the broader community in achieving their goals and outcomes.

> ***The work ACHs do around convening partners, creating cross-sector workgroups, and partnering with existing community initiatives creates the conditions for greater impact on community health than one organization could have on their own.***

Four important themes have surfaced related to the value ACHs bring to the community:

- **Creating a framework for multi-sector collaboration and collective accountability,**
- **Advancing equity and elevating community voice,**
- **Catalyzing alignment across partners to build capacity and secure funding for sustainability, and**
- **Providing a concrete vehicle for prevention and addressing health related social needs.**

ACH ACCOMPLISHMENTS: SYSTEMS CHANGE

At its core, CACHI is a systems change initiative aiming to transform and align norms, practices, and policies to improve health equity and long-term population health outcomes. Because systems change work is developmental, complex and takes time, a key aspect of the evaluation was to track both progress toward, and achievement of systems changes across the sites.

Over the last five years, ACHs made demonstrable progress in solidifying the core ACH model elements necessary for creating the conditions for longer term systems changes. Key markers for progress toward systems changes include: enhanced knowledge, strengthened relationships, increased individual and organizational capacity, and strengthened champions and community ownership. For example, ACHs deepened relationships and expanded cross-sector partnerships to build strong, adaptable coalitions that bring value to their key stakeholders; established distributed leadership structure across partners and work groups to engage diverse partners and community leaders; and made racial equity more explicitly part of their aims, work, and operations, including community engagement approaches, data collection, and reporting practices to examine disparities.

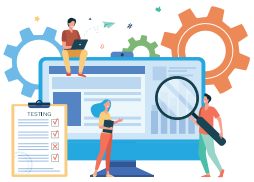
Moreover, ACHs achieved actual systems changes related to transformed norms, changes in practices within and across partners, securing new and sustainable funding mechanisms, and advancing policy changes. For example, ACHs created trust among their community partners that enabled them to move from competition for resources to collaboration around shared goals and activities; identified gaps and created new community-clinical interventions that spanned health and community sectors and served to enhance service referral, linkage and care coordination across a variety of health and social issues; and served as a strong, credible advocate for community interests, working with local leaders to secure projects/benefits for current and future residents (e.g., local hire, affordable housing, health services, etc.).

LESSONS LEARNED FROM CACHI IMPLEMENTATION

Over the course of CACHI implementation, there were several important lessons learned that can help inform future ACH implementation as the model scales and spreads to other geographies within California and nationally. These include:

1. A dedicated, skilled, and well-compensated backbone organization is critical to ACH effectiveness and success.
2. The Portfolio of Interventions, which sets the CACHI model apart from other multi-sector collaboratives, gives the ACH a recognizable purpose, plan, and identity.
3. Community member engagement in ACH efforts is essential to advance equity and achieve collective accountability.
4. ACHs that have access to data and clear measurement strategies are better able to prioritize their work to areas of greatest need, demonstrate results, and communicate successes.
5. Financial sustainability of the ACH depends on partnerships, creative and joint problem solving, and aligning to local and state initiatives and priorities.
6. Transformational changes in CACHI are complex and technical assistance (TA) support is essential in addressing the many inter-dependencies that emerge in implementing the key model elements.
7. The historical context of partnerships and power dynamics within communities matters, and shapes and influences all aspects of ACH development and implementation.
8. Communication and messaging about CACHI to external audiences is a profoundly significant endeavor.
9. Turnover of key leaders and partners is inevitable and offers opportunities for building resiliency and innovation in the long run.
10. Community stewardship and collective accountability are pre-conditions to lasting systems change.

CONCLUSION



Overall, CACHI demonstrated that ACHs bring significant value to communities while facilitating transformational change—by promoting collaboration, equity, and sustainability in all efforts to improve health outcomes.

The original CACHI theory of change was shaped significantly by the policy context in 2015-16 when the federal government was moving toward payment reform. The ACH was conceptualized as a pathway for creating a transformed health system to facilitate this reform. With the 2016 election, the focus of CACHI shifted to addressing issues of equity and community health through collective action. Over the course of implementation, community ecosystems were disrupted and impacted by political unrest, a global pandemic, environmental disasters related to climate change, and various other local, national, and global challenges. In this context, the ACH has proven to be resilient and effective in enabling the necessary cross-sector collaborations required to advance toward addressing health inequities and improving community health.

In 2022, the state legislature recognized the achievements and promise of CACHI by allocating $15 million to scale and spread ACHs to more communities across California with oversight by the California Department of Public Health. With additional support from The California Endowment, Blue Shield of California Foundation, and The California Wellness Foundation, a total of 37 (13 original and 24 new) ACHs have received 30 months of funding starting July 1, 2023, to further build and sustain the ACH infrastructure locally by aligning with state initiatives to focus their collaborative work. The goal is to demonstrate the value ACHs can play in the local implementation and impact of state initiatives such as Integrating Children and Youth Behavioral Health, Partnering with Managed Care Plans to Reduce Health Disparities, Strengthening Community Resilience, and Coordinating Health Workforce Needs.

SECTION 1 | INTRODUCTION AND OVERVIEW

Improving community health and equity requires thinking beyond the health care system to health-related social needs and the institutions and policies that shape them. This expanded view of community health requires expanded partnerships as no single organization or system has all the tools needed to effectively address complex issues and problems. Multi-sector collaboration is now a favored approach to community health improvement. As such, Accountable Communities for Health (ACHs) are now well recognized as a vehicle for multi-sector collaboratives to address community health issues by coordinating clinical providers with public health departments, schools, social service agencies, community organizations, and others, in a collective effort to make a community healthier. In June 2022, the Funders Forum on Accountable Health was tracking more than 150 ACHs or ACH-like entities across the country (Funders Forum on Accountable Health website).

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ABOUT THE MODEL

Conceptually, the CACHI model (see Logic Model Appendix 1) centers around equity and a Portfolio of Interventions (POI), a set of mutually supportive interventions that address a particular issue or condition. A backbone agency, cross-sector partnerships and leadership, and governance arrangements all serve as foundational infrastructure for the ACH to work towards a shared vision. Robust community engagement shapes the ACH vision as well as the design and implementation of the POI, and community members are among the groups to which CACHI ACHs are accountable. Finally, the model specifies that ACHs use data to set direction and monitor and communicate progress toward their goals, and Wellness Funds are established to attract resources and sustain their work for the long term. The CACHI model is unique but shares some elements of other multi-sector frameworks (e.g., Collective Impact (Kania & Kramer, 2011) and Aligning Systems for Health (2021)).

ABOUT THE SITES

Thirteen ACHs from across California participated in CACHI from 2016/2017 to early 2022. Each site has a specific geographic focus, ranging in size from an entire county (e.g., Imperial County) to a neighborhood or part of a city (e.g., South Stockton). As part of their CACHI funding, each ACH selected a community health priority or set of priorities around which to focus their POI such as cardiovascular disease, nutrition, or community violence and trauma. Appendix 2 provides an overview of each ACH, including the backbone organization, target condition, and geography. Appendix 3 provides brief narrative descriptions of the ACHs and the focus of their work. Between 2017 and 2019, the thirteen sites were placed into two cohorts: six in a 'Catalyst' group that was working to implement all key components of the CACHI model and seven in an 'Accelerator' cohort that focused primarily on foundational ACH infrastructure and received less funding. Beginning in September 2019, the two cohorts were merged.

ABOUT THE LEARNING EVALUATION

Along with funding for sites, technical assistance, and a variety of convenings and events, CACHI sponsored an initiative-level learning evaluation starting in 2017. As a learning evaluation, the focus has been on documenting progress, successes, and challenges, and exploring the contributions that ACHs make toward systems change and improved community outcomes. The goal was to understand the value ACHs can bring to their communities and settings, and to identify structural, programmatic, and contextual elements relevant to spread and scale of the ACH model. Guiding research questions addressed in this final report include:

1. What is the value of an ACH in advancing community health priorities?
2. What were the implementation experiences and the factors influencing them across the 13 CACHI sites?
3. What were the accomplishments of and lessons learned from CACHI?

Over the course of the evaluation, a variety of data sources and data collection strategies were used, including:

- Quarterly check-in calls and conversations with backbone staff at each ACH.
- Annual site visits (in-person or virtual) to each ACH to meet and interview leadership team members, backbone staff, core partners, and community stakeholders.
- Notes from a series of three 'CACHI reflection' conversations with ACH

backbone staff and key stakeholders (past and present), convened by the CACHI Program Office between December 2021 and February 2022.

- An annual survey of ACH partners asking questions about ACH progress, challenges, strengths, impact, and value. Community members participating in ACH workgroups or leadership bodies also participated in the survey. The most recent partner survey was conducted February through March 2022.
- Periodic observation of ACH leadership and community meetings or events.
- Review and coding of ACH materials such as reports, presentations, meeting records, and communication materials, and of sites' CACHI grant reporting documents. For this evaluation report, ACHs' final CACHI grant reports and supporting documentation were a particularly important resource.

ABOUT THIS REPORT

This report is based on findings from the external evaluation of CACHI conducted by Desert Vista Consulting, the Center for Outcomes Research and Education (CORE), and AGD Consulting. The report documents accomplishments, challenges, value and impact, and lessons learned across the 13 ACHs, which can inform the spread of ACHs across California during the next round of CACHI funding.

For a summary of the key individual ACH accomplishments in the last grant year and over the course of CACHI, please see Appendix 4.

OVERALL VALUE OF THE ACH

The evaluation found that California ACHs are in an ideal position to align cross-sector strategies and improve community health by creating bridges among county agencies, health care systems, health plans and communities. The ACH structure enables sectors, organizations, and residents to coalesce and align to address and transform the socio economic, environmental, and various structural conditions that impact the health and well-being of communities.

The work ACHs do around convening partners, creating cross-sector workgroups, and partnering with existing community initiatives creates the conditions for greater impact on community health than one organization could have on their own.

Communities can leverage the ACH infrastructure to demonstrate to funders that the community is aligned in achieving certain goals, thereby increasing funder confidence in making investments. Finally, many California ACHs have identified ways to incorporate equity and the community voice, not only by including community members in meetings and offering translation services, but also by addressing diversity across all aspects of the governance structure to ensure ACH activities reflect community needs and priorities. The longer ACHs work within their communities, the greater their capacity to provide and demonstrate value to organizational partners and the broader community in achieving their goals and outcomes.

Four important themes have surfaced related to the value ACHs bring to the community:

- Creating a framework for multi-sector collaboration and collective accountability
- Advancing equity and elevating community voice
- Catalyzing alignment across partners and the community, providing a new approach to identify, develop, and implement interventions and activities, and build capacity and secure funding for sustainability
- Providing a concrete vehicle for prevention and addressing health-related social needs

ACH Infrastructure Creates a Framework for Multi-Sector Collaboration and Collective Accountability

ACHs create bridges between health care systems, payers, and communities, and they address social determinants of health by working upstream to improve health equity and outcomes. In addition to bringing cross-sector partners to the same table for collaboration, ACHs create clinical-community linkages to improve access to services and strengthen the continuum of care in a community. In many CACHI sites, the ACH aligns multiple complementary, cross-sector system change initiatives tackling

different components of community health rather than implementing these strategies in isolation. Through collaboration across diverse, multi-sectoral partners, ACH members build trust, break down silos and can advance their work beyond what any partner is able to achieve individually, which ultimately results in improved service delivery and outcomes for residents.

> *I don't have anything to compare this level of collaboration to. I think one of our biggest accomplishments is breaking down silos and working together. At the end of this, there are organizations and sectors that continue to be engaged together.*
>
> **— San Gabriel Valley, Reflection Series**

The ACH structure creates the conditions for participating stakeholders—individuals, organizations, and sectors—to transcend their respective internal interests by collectively maximizing financial and non-financial resources to support a common goal or address a shared need. Data are shared and common measures are used to facilitate a shared understanding of the problem, solutions, and to demonstrate outcomes. Collaboration becomes part of the "culture" and way of doing business.

Advancing Equity and Elevating Community Voice

ACHs made racial equity more explicitly part of their aims, work, and operations. ACHs are deepening their work around health equity by incorporating community members into the governance structure, examining the historical causes of disparities, creating frameworks and tools for advancing equity work across sectors, and prioritizing racial and health equity in ACH decision-making.

Through outreach, engagement, and true collaboration, ACHs create a platform for residents to be heard, to shape strategies, and define challenges and solutions. ACHs provide access points and opportunities for community members to be in the room with health system leaders, health plans, city officials, and a range of other partners that hold decision-making roles and power. Advancing equity and incorporating resident voice in policy and advocacy efforts ensures that priorities of local government align with community health needs.

> *Community identifies HICP as the place where they can speak out, have space to share experiences with the health care system and they will be listened to.*
>
> *They know a range of agencies are represented in the partnership and if they raise a question or issue we can't answer, we will follow up to get that answer.*
>
> *Our community is 95% Spanish speaking and our meetings have been held in both English and Spanish early on to facilitate participation.*
>
> **— HICP, Boyle Heights, Backbone**

Catalyzing Alignment to Build Capacity, Secure Funding for Community Priorities, and Maximize Impact

ACH infrastructure encourages collaboration and communication about issues and initiatives, and it also provides a foundation for securing funding that benefits the community. ACHs identify funding opportunities that build on collaboration across ACH partners and align with ACH goals for community health improvement.

Leveraging the ACH infrastructure and demonstrating a history of collaborative work are attractive to funders that want to make cross-sector impacts. Having a collective mindset around funding (e.g., collaborative grant writing, reduced funding hoarding, etc.), can facilitate the shift from competition to collaboration to reach a common goal of expanding capacity across a shared service landscape.

Beyond enabling funding victories, ACH alignment yields greater impact by enacting strategically coordinated, interlocking interventions that leverage the resources of all partners to maximize community benefit.

> *"The ACH is both a platform and a connector. It provides value through education and sharing expertise, and outlining actionable steps to position our collaborative and community to be a player in future statewide initiatives.*
>
> *The ACH provides the platform to make this case. Working together, sharing expertise and funding, rather than competing – it's a great day when all of this comes into play."*
>
> **— Fresno, Backbone**

Providing a Concrete Vehicle for Prevention and Addressing Health-Related Social Needs

ACHs provide a concrete vehicle for thinking more upstream about community health and addressing the health-related social needs that impact health outcomes. Placing specific attention, financial and human resources on prevention was also part of the original CACHI intent. ACHs created alignment with their partners around moving upstream and addressing factors community members identified as most salient to health.

> *"Pre-COVID we had community connectors and resident leaders that wanted to focus on social connectedness, but this wasn't on the radar of health sector partners.*
>
> *We were more focused on heart disease, but the community made a case for it, they described challenges that residents faced and what impact that made.*
>
> *We did some research on social connectedness and found all these connections to heart disease, and this lifted up a whole new area for us.*
>
> **— West Sacramento. Stakeholder**

Supporting community members during the COVID pandemic and investing in Community Health Worker (CHW) network development were specific activities that helped shift the focus toward prevention and earlier intervention (e.g., food distribution, vaccine education, and other efforts related to health-related social needs) while also supporting linkage to clinical intervention when needed.

Table 1 summarizes the perceived value and impact of the ACHs according to participating partner organizations. Overall, a majority (70%) of partners reported that the ACH promoted a common understanding of community needs and priorities and strengthened the capacity of partner organizations to work toward shared goals. Additionally, over 60% of partners indicated that the ACH helped trust building among partners and stakeholder and elevated issues of health equity and social justice. Given that mindset and systems change takes time, it is important to note that more than a quarter of the organizations reported changing policies and practices to support collaboration with other partners because of their work with the ACH.

Table 1. Partner Feedback on ACH Impact (12 sites), 2022 CACHI Wrap-Up Survey (n=98)

A. The ACH ...	%
Helped to foster a common understanding of community needs and priorities	71%
Strengthened the capacity of organizations in the community to work together towards shared goals	70%
Enhanced trust between organizational partners and community stakeholders	65%
Elevated issues of health equity and racial justice	63%
Changed my/my organization's understanding of community needs and priorities	57%
Changed the way I/my organization engages and works with community members	57%
Brought in financial resources to advance collaborative work	48%
Prompted new agencies or groups to take a lead role on ACH priorities	38%
Changed my/my organization's approach to health equity and racial justice	37%
B. Through our work with the ACH, my organization ...	
Engaged new and/or existing partners more deeply to advance the ACH vision	62%
Partnered with other organizations to pursue funding opportunities rather than going it alone	57%
Shifted beyond short-term programmatic work toward longer term systems change efforts	38%
Changed policies or practices to enable alignment and collaboration with other partners	27%

SECTION 2 | FINDINGS: IMPLEMENTING AND SUSTAINING THE KEY ACH MODEL ELEMENTS

The CACHI model specifies an array of key elements that constitute an ACH, including:

- Health Equity
- Shared Vision and Goals
- Governance, Partnerships, and Leadership
- Backbone Entity
- Portfolio of Interventions
- Community and Resident Engagement
- Data Sharing and Analytics
- Wellness Fund

KEY TERM

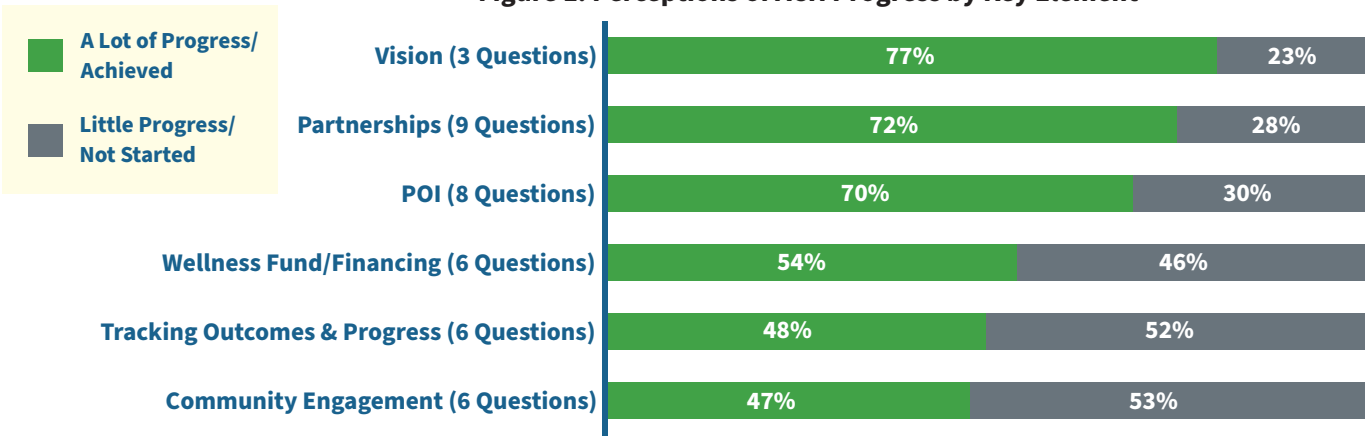
Portfolio of Interventions:

A set of mutually reinforcing interventions and activities that are strategically aligned and implemented to address a community's goals.

These key elements are dynamic, operate interdependently, and reinforce each other to yield greater alignment and coordination among partners and impact from interventions. For example, an ACH's vision for change influences the partners that are needed at the table; and the vision and portfolio of interventions (POI) help specify what data are needed to support ACH operations and assess whether the ACH is making a difference. Along with being interdependent, the key elements are dynamic and evolving. Over the course of the initiative, even the key elements (e.g., vision or backbone entity) that might be considered more foundational have transformed in several of the sites in response to changing needs or community context. Examples of these are discussed in more detail in the following section.

In this section, we examine the role and significance of each CACHI model element as they were interpreted and executed across the thirteen sites. **Figure 1** provides an overview of perceived ACH progress in implementing the key elements, followed by an aggregated assessment of progress, including challenges and key learnings.

Figure 1. Perceptions of ACH Progress by Key Element



Data Source: 2021 CACHI Partner Survey (n = 149 respondents, 12 sites)

A. Core ACH Infrastructure: Backbone and Governance, Partnership, Leadership

Two key elements of the CACHI model—backbone and governance (with partnerships and leadership)[1]—constitute the core infrastructure of an ACH. Together, they create the scaffolding that enables groups and organizations from across different sectors and communities to build relationships, develop a shared vision for change, and design and implement coordinated interventions.

CACHI sites made considerable progress on these key elements over the course of the initiative. Governance, partnerships, and leadership were the components for which ACHs reported the highest number of completed milestones at the end of the CACHI period. Despite challenges both global (e.g., the COVID pandemic) and site-specific (e.g., turnover or loss of key personnel), most ACHs succeeded in building strong, adaptable collaboratives that bring value to their key stakeholders.

Value of the Backbone

Every major aspect of ACH operations depends on the backbone, from practical tasks like planning and facilitating

BACKGROUND

Key Functions of a Backbone Organization

(ACH Infrastructure Fuels Change www.cachi.org/core-library/204)

- **Elevating Community Voice**
  - Inform, engage and activate community leaders and residents
  - Ensure residents have a role in decision-making
- **Facilitating Action**
  - Convene stakeholders for cross-sector collaboration
  - Identify community assets
- **Building Sustainability for Impact**
  - Design and manage ongoing governance and infrastructure
  - Maintain communications between partners and the community
  - Facilitate fundraising and develop sustainable financing
- **Stewarding Systems Change**
  - Oversee alignment of existing stakeholder-defined strategies
  - Identify gaps and new solutions
  - Adopt new collaborative practices among partners and community
- **Influencing Policy**
  - Identify and elevate community issues
  - Advocate for local and state policy change

[1] | Most of CACHI program documentation presents these as two key components: (1) governance, partnerships, and leadership, and (2) the ACH backbone entity. Because they are closely connected, they are discussed together in this report.

meetings to more intangible work like building trust or supporting execution of 'distributed leadership' as expected in the CACHI model. As such, ***the backbone is a critical factor in the effectiveness and success of ACHs.*** In the final evaluation survey of CACHI partners, several stakeholders cited the backbone agency as their ACH's greatest strength, while others described the backbone itself as an intervention on the same level as other efforts under the ACH's portfolio of interventions.

Performing all the backbone functions requires a broad skill set. The original developers of the Collective Impact framework described effective backbone leadership as being visionary, results-oriented, and focused but adaptive. Among the skills deemed necessary for backbone staff are collaboration and relationship building, political savvy, charismatic and influential communication, and humility (Turner et al., 2012). CACHI backbone staff and ACH partners highlighted additional important skills, including:

- Having a big picture or system-level perspective, i.e., "being able to connect the dots or highlight the ripple effect"
- Knowledge of and expertise in the local health care and social services ecosystem
- Expertise in community engagement
- Change management and negotiation skills
- Consistent, long-term commitment to the work, e.g., "*They are well organized, they 'get it', they work hard, they report out, they look ahead.*"

A backbone staff person from East San Jose described the role as "*…being accountable. Being ready to respond, act, facilitate, host, convene. That requires relationships and organizational structure at the same time. That means really listening and hearing where we are going collectively.*"

Championing equity is another key aspect of the ACH backbone's role. ACH backbones have:

- Led or co-led efforts to explicitly include equity in the ACH's vision and purpose
- (Re)examined ACH membership, priorities, and community engagement practices with an equity lens
- Arranged for training and technical assistance to help ACH partners develop capacity to address equity more directly (Public Health Institute, 2022)

For example, the Fresno Health Improvement Community Partnership (FCHIP) hosted a series of six diversity, equity, and inclusion workshops in 2020-21 on topics including: Building a Healthier and Equitable Fresno County by Advancing Racial Justice, Dismantling Racism, and Collective Action to Achieve Health Equity.

In Sonoma County, the backbone agency used CACHI technical assistance funds to offer racial equity coaching to help ACH committees, chapters, and partner organizations to operationalize racial equity at both individual and collective levels.

Finally, building trust, strengthening relationships, and expanding partnerships are hallmarks of the backbone's value. ACHs exist as vehicles for collaboration across multiple sectors to address critical community health issues. Robust partnerships are critical to collaboration and trust-building and have been a consistent part of ACHs' work since their initial efforts to establish (or refine) a collective vision at the outset of CACHI.

Staff and stakeholders from many CACHI sites describe their success in establishing strong, collaborative relationships as one of the ACH's key accomplishments. For example, Long Beach's ACH, All Children Thrive Long Beach, established a mutual aid network amongst the steering committee in 2020. This network removed barriers to the sharing of information, supplies, and resources and sped up the process of collaborating to meet community needs.

Successes and Accomplishments

- ACHs have ***built trust and established strong partnerships*** in large part by relying on the work and abilities of backbone agencies that have provided consistency, skilled facilitation, attention to power dynamics, strategic outreach and engagement, and demonstrated accountability. Doing this successfully requires significant time and effort.

KEY ACCOMPLISHMENT

Relationships and Trust Building

(2022 Partner Survey)

"Building sustainable trust between the partners, who ordinarily work in silos, has allowed for the cross-sector approach to work."

"To accomplish more, we need to band together as often as opportunity arises. The ACH process reminded/taught us of that factor. Sharing the work, sharing the governance, sharing the impact was all significant to raising awareness of the ACH model and the ability to lift heavier loads collectively."

"The biggest change is the importance and place of community—residents talking to neighbors and bringing information into the ACH so we can change when needed. The trust is changed between organizations and residents. Engagement, communication, and trust."

"[The ACH] has enhanced relationships with organizational partners and set up a strong foundation for future collaboration."

For example, Healthy San Gabriel Valley has been tracking all the individual and small group conversations that occur in between official ACH meetings because those contacts are "what really galvanize these relationships." Over the course of one year, they recorded almost 240 meetings with more than 50 unique partners outside of formal ACH workgroup meetings. For building connections and trust between organizations and community members, ACHs have employed a broad range of strategies discussed also in the next section.

- Another key strategy ACHs employed to build collaborative relationships was serving as the ***neutral convener***. Especially as they were first forming, many ACHs and their backbone entities intentionally avoided competing for resources with other organizations or coalitions in the region and "picking winners and losers" with their funding or intervention decisions. Across all years of the initiative, ACHs applied for grants and pursued other financing strategies to fund the backbone, as well as share directly with ACH partner organizations.
- Clearly ***defining the role of the ACH with respect to other groups*** was another success factor. For example, in San Diego, backbone staff explained that: *"honing in on our specific strength and niche of community-clinical linkages was key for us in San Diego as it allowed partners to see what lane we were in and that it was not competitive to their lanes."* Importantly, most ACHs (including San Diego) found it necessary to balance the neutral convener role with active leadership at times to maintain ACH momentum, advance interventions that other entities did not have the capacity to take on, and to uphold the ACHs' values and commitments.

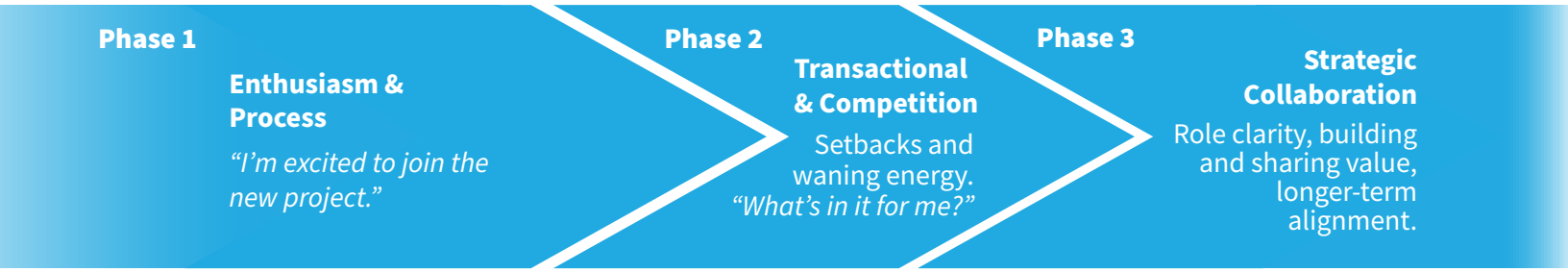
Challenges

ACH backbones faced a range of challenges living up to their broad set of accountabilities. Some were external, including the pandemic, devastating wildfires in Northern California, or an unexpected outcome in the 2021 mayoral race in Stockton. Other challenges resulted from turnover among key backbone staff and, like many multi-sector collaboratives, keeping partners and the community engaged by finding the right balance between process or infrastructure work and 'getting to action' (Georgia Health Policy Center, 2021). Additionally, ACHs experienced challenges given the limited expertise within the backbone and because partners were carrying out more of the technical work related to using data to track progress and outcomes, as well as developing financing strategies to support sustainability and build the wellness fund.

- The most common challenge for backbone agencies was ***workload and capacity***. Over the course of the initiative, backbone staff frequently reported having to prioritize which aspects of the CACHI model to focus on, in part due to limited staff capacity and financial resources. The most recent CACHI

Partner survey asked what limitations, if any, the ACH faced in achieving its goals. Several respondents cited backbone capacity as a constraint, e.g., *"[the backbone] has done a wonderful job with the resources available, but additional staffing would help the collective to grow and achieve more of its long-term goals."*

» ***Consistency and depth of partner involvement*** was also a challenge for most ACHs at one time or another. As documented in the 2019 interim evaluation report, the following notable three-phase pattern of partner involvement and commitment to the ACH as a vehicle for collaboration and transformation emerged.



It is one thing to attend meetings to make connections and provide input, but actions such as contributing data, providing funding, executing contracts, or changing business practices require a different level of commitment from partners. In the final evaluation survey of CACHI partners, a majority (over 60%) of respondents reported that their participation in the ACH had led to deeper engagement with partners, but fewer than a third (27%) reported changing organizational policies or practices specifically to enable collaboration. ACH partners faced many of the same constraints as backbone agencies including staff turnover or leadership changes, multiple competing priorities, limited resources, and the overall impact of the pandemic.

ACH Highlight | Healthy San Gabriel Valley — All In For Azusa

To support continued relationship development and collaborations, and to help demonstrate the value of their collective efforts, this southern California ACH partnered with Visible Network Labs to conduct a network analysis of partnerships across the ACH in 2021. They found 148 distinct partnerships across 24 participating organizations and a variety of levels of organizational involvement with the ACH. Interestingly, the network analysis revealed that the top three most densely connected organizations in the network were public entities (two cities and a local school district), although the ACH backbone was—unsurprisingly—also well connected. The data collection for the project also included questions about priorities and barriers to effective action. The ACH will use these results to inform its programmatic and network development strategies moving forward.

B. Community and Resident Engagement

Community engagement is a core value and set of strategies within the CACHI model. Also known as community participation, resident participation, and community voice and power sharing, community engagement refers to the "process for working collaboratively with groups of people who are affiliated by geographic proximity, special interests, or similar situations with respect to issues affecting their wellbeing" (Centers for Disease Control, 1997). As such, health and wellbeing programs and policies must be driven by and reflect the needs, assets, and interests of the community or population of focus—those with "lived experience" and their associated community-based organizations.

ReThink Health, a technical assistance provider to CACHI, developed a **"Resident Engagement Practices Typology"** (Rippel Foundation, 2018) that categorizes resident engagement into three outcomes multi-sector partnerships can achieve:

- **Increasing resident awareness and participation** in the services provided by organizations, for example, by sharing information or providing services in the community.
- **Getting feedback and input from residents** to improve services, processes, or policies, for example, through surveys or listening campaigns.
- **Supporting active resident leadership** by creating the conditions for large groups of residents to lead and be involved in transformational efforts, for example, by providing grants for resident-driven initiatives, training residents as community organizers, or training residents to hold leadership positions.

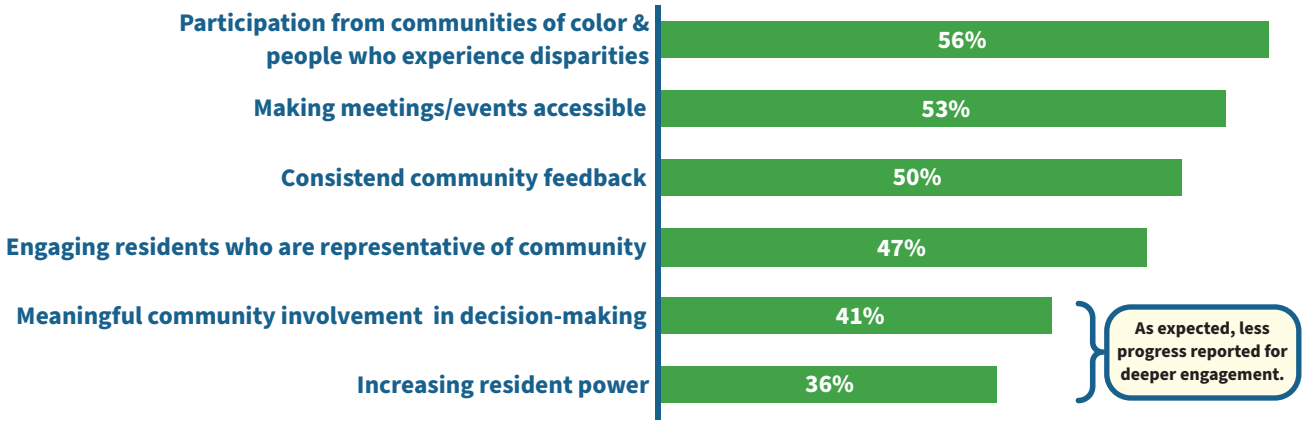
As detailed in the ACH Milestone Checklist[2] (Appendix 5), the primary areas of engagement for residents and the broader community are the ACH's governance, as well as the design and implementation of activities and interventions. ACHs were expected to communicate regularly with and involve residents meaningfully in the governance and action structures (e.g., leadership team, work groups, etc.), and provide support for their participation by adjusting meeting times and processes and offering training or stipends.

Overall, ACHs did well in implementing certain aspects of community engagement. The majority reported on the ACH 5-Year Milestone Checklist that residents actively participated in the ACH, and resident leaders were supported while participating. Most ACHs also said they communicated with residents about the POI. However, fewer ACHs said residents and CBO representatives were engaged in decision-making capacities or active in shaping ACH priorities and intervention implementation.

2 | Milestone Checklists are a tool for ACHs to document their progress across a series of milestones and indicators in each stage of growth.

Partner survey findings showed a similar pattern, with respondents reporting greater progress among the ACHs in increasing resident awareness and participation and obtaining resident feedback and input compared to supporting active resident leadership and power sharing (**Table 2**).

Table 2. Perceptions of Progress: Community Engagement



Note: "Don't know" responses removed. | Data Source: 2021 CACHI Partner Survey (n = 149 respondents).

Value of Community Engagement

There is a growing recognition that community engagement and health equity are inextricably linked. "*It is only with community engagement that it is possible to achieve and accelerate progress toward the goal of health equity through transformed systems for health*" (National Academy of Medicine, 2022). Across the board, the sites committed to strengthening their community engagement work to advance their health equity goals.

Successes and Accomplishments

Several ACHs made significant progress in getting feedback and input from residents by inviting community members to meetings or soliciting their input in community health needs assessments (e.g., San Diego, Boyle Heights, Lake, Fresno, Sonoma). In addition, ACHs like Boyle Heights and Stockton became known by other organizations as the best place to obtain community input, for example, for capital or housing projects. Boyle Heights also offered simultaneous English/Spanish translation of their meetings, as well as all materials in both languages. The Long Beach backbone educated their steering committee about how to partner with community members and be sensitive to their perspectives.

Some ACHs also made progress supporting active resident leadership by hiring and training community members, paying residents to attend meetings, incorporating

community committees into the governance structure, and empowering residents to make decisions about funding and resources.

Examples include:

- **Hiring and training community members:** Stockton hired two "Trustbuilders," or outreach workers, to link community members with resources. San Diego created the Neighborhood Networks program in which they worked with CBOs to hire and train "navigators." Implementation of the community health worker model in multiple communities (Merced, South Stockton) also served to train and pay community members for their expertise. Long Beach trained "Family Leaders" – a group of mothers who served as liaisons with the community and elevated the community voice.

- **Compensating residents for meeting and/or leadership teams:** South Stockton paid residents for their time on committees. They secured funding from a health plan, hospital, and community bank. East San Jose also secured funding for gift card payments for meeting participation.

- **Empowering residents to decide on distribution of COVID funding:** Residents and community partners provided input on how to distribute COVID-relief funding (West Sacramento, East San Jose, Long Beach). West Sacramento implemented a resident mini-grant program in Fall 2020 to give **residents a voice about community solutions for ACH priority areas.**

- **Incorporating residents into the governance structure:** East San Jose identified resident leaders who already worked closely with the county public health department and other key CBO partners. These leaders later became co-chairs at the leadership team and workgroup levels. San Diego incorporated the community voice into its governance structure by creating the Community and Resident Engagement Workgroup (CREW). The chair of this committee participated in the Stewardship Group.

Challenges

- **Authentic engagement of residents requires compensation and accommodations.** Very few ACHs were able to compensate residents for participating. To do so, ACHs needed to secure additional funding for this purpose, and not all funders are willing to devote the necessary dollars. Government backbones had to identify a mechanism for issuing payment that met bureaucratic requirements. ACHs also experienced challenges adapting their meeting processes to meet the needs of all involved, including community members, such as scheduling meetings when residents could attend, providing childcare, offering translation, and educating other committee members on how to be welcoming to residents.

- **Understanding community members perspectives and expectations may require different approaches than are typically utilized by system professionals.** Strategic or program planning processes, which may be familiar to professionals working in the field, are not necessarily acceptable to residents. For example, the East San Jose PEACE Partnership found that community members tended to be less patient with "planning heavy" processes and wanted to quickly identify ways to improve their own lives and those of other residents. The PEACE Partnership tried to respond to their stated needs, but at the same time also tried to meet the needs of paid administrators and funders.

- **Backbone staffing needs to be adequately funded to support resident engagement.** Successful and sustained community engagement requires dedicated time commitments to cultivate new relationships, and support ongoing involvement, including "going into the community" to hear what residents have to say. In some cases, staff may need to build trust in communities of color to counteract past experiences of discrimination and input not being valued. Building trust and relationships is essential, requiring adequate funding for backbone staff to dedicate the necessary time.

- **Commitment to authentic community engagement requires flexibility and a willingness to change priorities and directions.** A true commitment to community involvement, ownership, and power sharing can result in ACHs having to change priorities, shift direction, or change implementation plans. Without this commitment and intention, community engagement activities can feel symbolic and tokenized. Additionally, communities are multifaceted, and while some groups may be represented, others may not, which adds a layer of complexity to community engagement efforts that needs to be recognized and addressed.

ACH Highlight | Reinvent South Stockton Coalition

The Reinvent South Stockton Coalition was particularly successful at engaging residents. They recently developed a definition of resident engagement at a retreat with the RSSC staff that says, in part, *"Resident engagement aims to build trust with Stockton residents by integrating them into RSSC's collective impact work in a way that is inclusive, culturally aware, and accessible… and where residents have a voice, decision-making power, and a leadership role."* Staff created resident engagement plans for each of their Result Areas and RSSC-led initiatives, and staff are now reporting on progress at their weekly staff meetings.

RSSC supported County Public Health Services in a successful proposal to the Centers for Disease Control that is funding 10 additional **CHW positions** over three years, most

of which will be placed at community clinics and community-based organizations (CBOs). For several years, two paid "**Trustbuilders**" (outreach workers) were placed within CBOs where they visit households and businesses to help individuals find supportive services. RSSC has also compensated residents for their time through their **Youth Engagement Project** in which they pay a stipend to 16 individuals ages 16-26 for their time as members of their Cradle-to-Career Youth Advisory Council (YAC). RSSC funds the gift cards through a grant from a local community bank. When the RSSC **Housing Justice Coalition** asked for community involvement in planning meetings, RSSC gave $50 Visa gift cards to the attendees of the two-hour sessions.

C. Portfolio of Interventions

The POI is at the heart of the CACHI model, representing the collective activity or the "engine of change" that the ACH is undertaking to achieve prioritized outcomes. The POI is where systems, the community, and residents come together to identify, develop, and implement interventions and activities that ultimately will achieve the ACH's vision.

According to the original RFP, the POI is based on the idea that in any given community, multiple organizations may be working on addressing the same problem or focusing on similar goals, but this often happens in silos without sufficient coordination to significantly improve population health. To strengthen their impact, ***the POI offers a strategy to more intentionally and strategically link and align activities and address gaps across organizations and sectors.*** The POI is the engine of the ACH where partners work together to "do business differently" and transform the systems[3] and community conditions that negatively impact population health.

In the CACHI model, there was an expectation that a well-balanced and robust portfolio would be responsive to community needs and include a mix of interventions, activities, and programs spanning multiple domains (e.g., Clinical, Community, Clinical-Community Linkages, Policy/Systems, and Environment). The intention behind organizing interventions across multiple domains was to provide ACHs with a structured process to analyze the existing interventions in a community to align and coordinate strategies for greater impact and identify potential gaps. Another expectation was that interventions in the portfolio would encompass a full range of upstream and downstream activities to address all stages and aspects of the community health issue. Early guidance on POI implementation included detailed definitions of the five domains to organize and structure the development of a comprehensive portfolio.

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3 | System is defined as a group of interacting, interrelated, and interdependent components that form a complex and unified whole. Systems change is defined as changes in the practices and operations of a system (e.g., culture, norms, decision-making authority, and resource distribution). Systems change results in shifts in "the conditions that are holding a problem in place".

Value of the Portfolio of Interventions

The POI creates the mechanism to align partners, facilitate collaboration, and enable service integration. As previously noted, the POI was envisioned as the engine of the ACH where partners work together to "do business differently" to address and transform the conditions that negatively impact population health. ACHs found the process of mapping existing activities and identifying gaps helped address siloed interventions by encouraging partners and stakeholders to understand and become familiar with each other's activities. This understanding in turn helped cross-sector partners coordinate, collaborate, and align their activities —and, ultimately, their resources— around a shared set of goals and outcomes for greater impact and effectiveness.

One of the key steps in developing the POI is having a clear set of goals and knowing what outcomes the ACH wants to achieve. It is important for the interventions, activities, and strategies that constitute the POI succesfully map onto the short and long-term goals of the ACH. In the CACHI model, goals and outcomes are "WHAT" communities want to change, the backbone and community partners are "WHO" will make it happen, and the POI is "HOW" the ACH will achieve its goals and vision. Coalescing and organizing collective actions around the POI is one element that sets the ACH apart from other multi-sector

BACKGROUND

Definitions of the five POI domains:

- ***Clinical services:*** **Services delivered by the health care system, including primary and secondary prevention, disease management programs, as well as coordinated care, provided by a physician, health team, or other health practitioners associated with a clinical setting.**
- ***Community and social services programs:*** **Programs that provide support to patients and community members and take place outside of the health care system (e.g., governmental agencies, schools, or community-based organizations). Community-based interventions frequently target lifestyle and behavioral factors, such as exercise and nutrition habits, and include peer support groups and social networks.**
- ***Clinical-community linkages:*** **Strategies to connect community and social services programs with clinical care to better facilitate, support, and coordinate health care, preventive, and supportive services. Interventions in the community-clinical linkages domain can help form strong bonds between community and health care practitioners.**
- ***Environment:*** **Social and physical environments that facilitate healthy behaviors. Environmental interventions aim to improve opportunities for physical activity, social connectedness, and otherwise support healthy behaviors.**
- ***Policy and systems change:*** **Public and private practices, rules, laws, and regulatory changes that affect how the health care and other systems operate and influence people's health. These interventions can address environmental issues, school policies, health, and social systems coordination, as well as financing to support prevention-related activities.**

collaboratives that convene to share updates on independent activities or engage in strategic planning. ***The POI is where action and outcome measurement take place, and where stakeholders hold each other accountable for results.*** For example, in Humboldt, POI implementation was supported by quarterly partner meetings with progress updates from agencies and identification of areas for alignment, and in San Diego, POI strategies are measured and tracked on a dashboard that is shared across community stakeholders.

Successful development and implementation of a POI required multiple strategies. ACHs that successfully established and implemented POIs to align and drive their cross-sector work developed strategic priorities and an initial POI through a community engagement process. ACHs that created POIs reflective of community needs and priorities committed to engaging and collaborating with the community using multiple methods, such as listening sessions, surveys, door-to-door community outreach, environmental scans, capacity mapping, and related strategies. Sites also leveraged existing community assets (e.g., programs and activities), as well as publicly available data during strategic planning and POI development.

Successes and Accomplishments

- **The Community-Clinical Linkage domain emerged as a catalyst to systems change.** One of the areas where ACHs experienced success is in the Community-Clinical domain in which they created interventions that spanned health and community sectors. Multiple ACHs established CHW Networks (e.g., San Diego, Fresno, Merced, Stockton) to enhance service referral and linkage and provide ongoing care coordination spanning a variety of community health and social issues. ACHs invested resources to train and support CHWs to work as bridges between hospitals, clinics, and individual providers and community member populations that are hard to reach or at-risk. The CHW network model is something that many ACHs are adopting as a sustainability strategy to engage health plans and managed care partners implementing CalAIM and other outreach, engagement, coordination, and care management efforts for their members. The clinical-community connection that CHWs create has been applied successfully across ACHs in a variety of ways, including creating trauma-informed networks, domestic violence service linkage, food and nutrition security assessment and referrals in healthcare settings, and chronic medical condition screening and follow up (e.g., cardiovascular health, asthma).

- **POI strategies fostered greater integration of previously separate services to increase service access.** Building on alignment of interventions, some ACHs are prioritizing the integration of programs and services across partner organizations. For example, The Teen Center in Azusa (part of the SGV ACH) created a centralized service access point and common calendar for all after-

school activities across sectors to serve as a one-stop shop for resource connection. During COVID, the West Sacramento ACH focused on "seamless" service delivery through partner coordination (e.g., pop-up vaccine clinics at food distribution sites) to increase efficiency of resource distribution and reduce burden to families in need.

- **POI development and implementation engages new and diverse partners.** Creating a POI across the continuum of prevention to intervention, and in multiple domains pulls in partners from multiple sectors beyond health. ACHs that worked across domains on root causes, upstream approaches, clinical intervention, and service coordination were able to engage a wide variety of partners who can see their unique role in creating a comprehensive system and approach to addressing community health priorities. For example, the ACH in Boyle Heights, Los Angeles, called the Health Innovation Community Partnership, engaged partners from the arts community through a project by the Civic Arts and Public Works Team that displayed local artists' work in the Restorative Care Village clinical setting. East San Jose PEACE Partnership partners include Next Door Solutions, a domestic violence agency and Stanford University Emergency Medicine Department, which led to successful collaboration on a proposal to create a formal learning collaborative for promotoras in the county.

- **When the COVID pandemic hit, ACHs were able to pivot their POI to respond to community need and the crisis at hand.** Having the infrastructure, relationships, and organizational framework of a POI allowed ACHs to mobilize quickly and identify COVID-specific strategies with their clinical and community partners. Stakeholders acknowledged the difficulty in balancing original community priorities, many of which were long-term community health issues, with the urgent needs and disparities that COVID elevated. Reframing the scope, geography, and interventions in the POI proved challenging, particularly for ACHs that had public health department staff in the role of backbone. In the final year of the grant, most ACHs were able to rebound and re-establish their POI activities even if on a smaller scale.

Challenges

Developing and implementing a POI with "mutually reinforcing" strategies across multiple domains proved to be challenging for most grantees, requiring significant pivots and technical assistance. Several challenges emerged with POI development and implementation, including a lack of certainty of where to start, how to involve partners in the process, and communicating with community members about the POI. For many ACHs, expectations around the timeline of POI development felt rushed and/or premature, and the language of a "portfolio of interventions" did not resonate

with many community audiences and was difficult to translate. Nevertheless, as indicated above, over the course of the initiative, ACHs had the most success focusing on a handful of strategies under the clinical, community, and clinical-community linkage domains.

COMMON POI CHALLENGES

- **Lack of certainty on where to start and how to involve partners**
- **Language was complex, conceptual, and hard to translate to community**
- **Moving from POI on paper to implementation**
- **Timeline of POI development felt rushed and/or premature for ACH**
- **Insufficient capacity to develop actionable POI**
- **Difficulty connecting interventions to outcomes**
- **Accessing data to demonstrate impact of interventions**
- **Difficulty balancing priority areas: long term strategies vs urgent needs**
- **COVID impact on priorities, scope, and geography**

- **While some ACHs found the POI structure helpful in identifying strategies and planning ACH activities, others found it too rigid.** Additionally, the task of identifying short, medium, and long-term strategies and their associated outcomes was not always conducive to creating a portfolio that was within the sphere of influence of participating stakeholders and resonated with and reflected the needs and priorities of the community. In some communities, even the word "intervention" proved problematic as partners debated what counts as an "intervention" – is this in the clinical sense or could it be key activities in the community? And some sites, such as Long Beach and San Gabriel Valley, preferred the socio-ecological framework they were already using. According to surveys and conversations with the backbone organizations, some ACHs stated there was insufficient expertise and capacity to develop and effectively monitor an actionable POI. Nevertheless, conversations about the "ideal" POI helped spark conversations about how to work together and, over time, the majority of ACHs successfully identified and implemented activities and interventions within their partnerships that were unique to the ACH.

- **Most ACHs managed to put together a POI within the first two years but struggled to move on from having a conceptual POI on paper, to an actual POI with multiple interventions implemented and tracked.** ACHs had difficulty connecting interventions and strategies to outcomes and securing

the data necessary to inform their ACH stakeholders on programmatic impact, let alone improvements in population health.

» **Future sustainability of POI varies across grantees.** According to final grantee surveys and interviews with the backbone organizations, the future of the POI is uncertain for many sites. Most sites expect certain aspects of the POI (e.g., aligning strategies across partners) will remain after the grant sunsets, but with modifications to allow the concept of the POI to evolve with the ACH priorities and direction. Most sites that invested in building CHW network capacity and/or creating clinical-community linkages are confident this aspect of the POI will be sustained. Other sites experiencing shifts in governance structure (e.g., Sonoma, Imperial) plan to let new leadership determine whether to take a POI approach for addressing system and community priorities. Some sites plan to modify or redefine many aspects of the POI to make this conceptual framework more accessible and relevant to system partners and the community (e.g., Boyle Heights, Humboldt, West Sacramento).

ACH Highlight | Humboldt Community Health Trust

The Humboldt Community Health Trust (HCHT), with backbone support from the North Coast Health Improvement and Information Network (NCHIIN), facilitated a clear sequence of steps to create their portfolio of interventions, resulting in a substantive, well-coordinated portfolio that was actively implemented by multiple partners and resulted in significant system changes during the grant period. The vision that guided their POI is: To address alcohol and other drug use disorders to cultivate a safer, healthier and more socially connected community.

HCHT developed their POI relatively quickly by using existing programs as the foundation and moving quickly into implementation. They started by conducting an inventory of existing programs, then sorted those into goal areas. They then identified metrics and data sources for each goal, using publicly available data as well as program data supplied by partners. This structured, strengths-based development process enabled HCHT to create a POI that was both immediately actionable and highly impactful.

After only a few meetings, HCHT had drafted a visual representation of goals, strategies, interventions, and metrics. HCHT implemented many interventions over the course of the grant period, though three stand out due to the tremendous impact they made in the Humboldt community: development of the Community Information Exchange, facilitation of Drug Medi-Cal huddles, and implementation of strategies to improve services to SUD clients during the height of the COVID pandemic.

D. Data Collection, Sharing and Analytics

Building data infrastructure and leveraging data to inform activities is an important function of the ACH. As outlined in the ACH Milestones Checklist, ACHs were expected to *"implement new and improve current capacities to collect, synthesize, and share data among partner organizations, and communicate progress transparently to communities and stakeholders"* using dashboards and communication strategies, such as persuasive narratives and visual aids. While progress was made in terms of data capacity and understanding how to use data for multiple purposes, it continued to be a component of the ACH model that was complicated for sites to advance given their limited access to clinical data, data sharing challenges, and technical expertise.

Value of Data in the CACHI Model

Implementing a data-driven approach to community health improvement helped prioritize issues affecting the community, increase awareness of existing health disparities and elevate the importance of equity. ACHs used data to understand root causes and contextual factors that influence outcomes and create system level gaps. ACHs that had access to data and clear measurement strategies were able to prioritize work around key needs, demonstrate results, and communicate successes to a variety of stakeholders in the community. Data collection and reporting by race and ethnicity, geography and insurance status helped ensure health equity was central to ACH activities with a continual examination of the status of community disparities. Finally, going through a process of identifying population health outcomes and indicators helped ACHs and their multi-sector partners focus on community health improvement goals and ways to measure improvement over time.

There was significant variation across sites in how data were used, collected, compiled, analyzed, and reported to convey ACH growth, progress, and impact. The following section highlights the most used strategies for incorporating data into ACH operations.

- **Using existing data to identify health priorities and select the service area for the ACH.** All sites examined some form of existing data to help identify the target issue or population of focus for the ACH. Sites leveraged data available through health sector partners (e.g., public health departments, hospitals, and health plans) to define the areas of greatest need. Findings from Community Health Needs Assessments were often used to prioritize issues to address and national indices (e.g., Health Priority Index) were used to understand geographic inequities that may define the ACH service area.

- **Community members served as an important data source in shaping ACH goals and outcomes.** Leveraging community knowledge to inform ACH priorities, strategies, and interventions was an important strategy for engaging community members and ensuring ACH activities reflect community

voice. Resident leaders played a vital role in understanding historical trauma and tensions, examining root causes of disparities, and understanding issues of trust based on prior experiences with various systems of care. Sites held focus groups, listening sessions, administered surveys, and conducted door-to-door outreach with community members to gather input on priorities and discuss strategies to address those priorities. The Boyle-Heights ACH hosted six learning sessions with more than 500 attendees across multiple neighborhoods in the community. Ultimately, they shifted their ACH focus from heart disease (a priority for the health department) to mental health and issues of health equity based on considerable feedback from community members.

> *While data reporting was suspended due to the pandemic, Hearts of Sonoma County partners took the opportunity to identify a revised set of measures toward achieving greater alignment in data reporting… and to begin tracking each measure by the demographic categories of race/ethnicity, gender, and insurance status.*
>
> **— Sonoma County Stakeholder**

- **Using data to examine health disparities.** Leveraging data to understand health disparities was put forward in the CACHI model as a priority for ACHs in their efforts to advance health equity. Its importance was reinforced as communities called for greater racial justice and demanded that community leaders do a better job of recognizing and addressing inequities. By using disaggregated data, several ACHs (East San Jose, Stockton, San Diego, Sonoma, and others) created intentionality around reporting data by race and ethnicity whenever possible, so as not to wash over inequities that might be hidden in countywide metrics. The need for disaggregated data was also highlighted during the COVID pandemic when ACHs gathered data on racial/ethnic populations that were not being reached by vaccination campaigns.

- **Implementing Results Based Accountability and creating public-facing data dashboards.** Several ACHs (San Diego, East San Jose, Sonoma, and Stockton) used the Results-Based Accountability model (Friedman, 2015) to better understand root causes and to select population health indicators. San Diego identified priority outcomes and indicators focused on cardiovascular health and created public-facing dashboards for their website. Stockton worked with their partners to select population health indicators, creating the SSPZ Data Scorecard for the South Stockton Promise Zone. Sonoma's Cradle

to Career project developed an RBA data dashboard to track educational attainment metrics and Santa Clara County (East San Jose ACH) developed a data presentation that includes population level violence prevention data. Additionally, with technical assistance support, sites such as Fresno developed infographic one-pagers to communicate ACH progress to the public.

- **Implementing population health and POI data collection procedures.** A few ACHs also established data collection procedures in support of their population health indicators and POIs. Organizational partners in the community that implemented POI activities often collected and shared data with the ACH backbone entity and stakeholders on a regular basis. East San Jose collected performance and outcome data related to the operational success of their ACH. The City of Long Beach contracted with the Long Beach Unified School District to implement the Early Developmental Index (EDI), which gathers data about how kindergarteners are faring in the community. For the San Diego nutrition security POI, the food bank partner reported quarterly on how many pounds of food were distributed in their region of focus. This type of data collection from POI partners was rare, however, due to many of the challenges described later in this section.

- **Community Information Exchanges.** Two ACHs pursued community information exchanges (CIEs), which provide the data exchange infrastructure that was mentioned in the original CACHI vision of data sharing and analytics. These data exchanges represented broader efforts to improve care coordination across partners in the community. The Humboldt Community Health Trust went live with their CIE on February 1, 2022 "after four years of research, discovery, financing, co-design, and partner engagement." The Fresno Community Health Improvement Partnership's (FCHIP's) Network of Care is participating in the development of a local CIE, building on previous work done in Fresno County. The CIE model continues to provide the necessary platform needed for true data exchange and is a promising strategy for cross-sector data exchange and service coordination.

- **Using data to communicate ACH impact.** Over the course of CACHI implementation, ACHs shifted their focus from collecting and reporting clinical outcome data on specific interventions in the portfolio (which was often unavailable), to creating a persuasive narrative that demonstrates ACH value to community stakeholders. To this end, several ACHs created communication pieces and online stories that use data to illustrate community concerns and potential solutions. Hearts of Sonoma County developed the CVD Data Story to illustrate the interplay of social determinants

of health and cardiovascular disease risk. Merced created an online story about "Rebuilding the Heart of Planada," an area within Merced County. West Sacramento, Long Beach, and Lake County also developed online data communication pieces that described the priority health issues and cross-sector strategies partners were developing in response. These stories and descriptions of need elevated awareness of the problems and focused accountability on how partners were acting and working collaboratively on solutions.

Successes and Accomplishments

The following provides a summary of key data related successes and site-specific examples of how data were used to advance ACH goals:

- **Collaborative data collection and analysis efforts**
  - **West Sacramento:** ACH partners compiled, shared, and reviewed comprehensive data to inform collaborative work including Community Health Needs Assessments, county health data, school health data, poverty data, emergency room data, hypertension management data, food insecurity data, and city planning data. The process surfaced heart disease as a place to start the collaborative work.

- **Increased data literacy and understanding of data analytics**
  - **Fresno:** Healthy Fresno County Community Dashboard allows users to compare community health indicators against state averages, county values, and target goals, and discover areas of excellence and improvement in the county.

- **Using data to address root causes of issues**
  - **Humboldt:** ACH partners used data to debunk a pervasive myth about a lack of access to treatment when in fact the issue was more complex and related to treatment beds being designated for certain payer types, etc. This was early impetus to improve coordination and referral management across the system, which led to development of the CIE.

- **Using population health data to develop strategies in the POI**
  - **East San Jose:** ACH examined neighborhood-level crime rates, education attainment, employment levels, income/poverty, health, the built environment, and other domains to determine which strategies would be most impactful for the POI.

» **Disaggregating data to highlight disparities**

- **Healthy San Gabriel Valley:** ACH partners joined forces to push the county health department to disaggregate data to avoid lumping the SGV community into broader Los Angeles county. Prior county data missed the story of the inequities in health care delivery, access, and prevention for those most vulnerable in the SGV region.

» **Implemented CIE to enhance information sharing and service coordination**

- **Humboldt and Fresno:** ACHs leveraged technology to support community-clinical linkages to track referral connections and service access (e.g., closed-loop referrals and coordinating infrastructure)

» **Increased public data sharing, storytelling, and accountability**

- Sites used data in new ways to develop dashboards and narratives to communicate with stakeholders on programmatic success.
- **Stockton:** ACH evaluates progress toward resident-led goals through key community-level indicators that are shared online in a data scorecard for continuous communication and accountability with the community.
- **Fresno:** ACH uses storytelling to remain accountable to the community and partners. This approach helps community members see the lived experience behind the data and charts and to fill in the blanks of what the data does not show.

Challenges

ACHs faced several challenges identifying measurable outcomes and indicators of success, and progress on data sharing and analytics was mixed. One of the more challenging aspects of data sharing and analytics was identifying data sources that aligned to the actual interventions and activities implemented by the ACH. ACHs experienced challenges gathering data that demonstrated improved community health, which is a long term outcome, and most focused on documenting improvements in cross-sector collaboration and system-level changes that are necessary to improve access to and experience of care.

» **Access to clinical outcome data.** ACH backbone organizations that were non-profit CBOs were often not able to collect, store and analyze data that are available to health system partners such as county government, health care providers or health plans. Securing data sharing agreements across systems of care to allow the ACH backbone to compile data across partners proved to be extremely challenging. Even ACH sites with public health departments as the backbone struggled to secure data from cross-sector health, education, social service, and justice partners.

- **Leveraging secondary data sources to demonstrate local efforts.** Linking ACH efforts or POI strategies to population health indicators at the community-level was a significant challenge. Typically, population level data have time lags making it hard to link the ACH interventions to longer-term outcomes. For ACHs in large counties, this was especially difficult because population health indicators are rarely available for smaller geographic regions that ACH interventions target. Lack of granularity in available community-level data made it challenging to address and measure improvements in health equity. Sites expressed frustration that health disparities data are often not available, especially for smaller regions and at-risk sub-populations.

- **Limited data analytic capacity and infrastructure within the ACH backbone.** A final challenge was that building capacity for data infrastructure and analytics is more technically rigorous than other essential elements of the CACHI model, and not all ACHs had adequate staffing to carry it forward. A specialized skill set is necessary to leverage secondary data sources, compile data from various sources, and analyze how ACH activities contribute to overall community health improvements. Effectively using data (e.g., dashboards) and translating data into compelling narratives for residents, new partners, and funders requires a level of expertise that may require external consultation and technical assistance.

ACH Highlight | San Diego

The San Diego Accountable Community for Health (SDACH) identified population health outcomes early in their development that would aid their aim to support ideal cardiovascular health across the lifespan. They adopted the American Heart Association's goal to improve cardiovascular health by 20% and reduce deaths from cardiovascular disease by 20% by 2030. Their population health indicators reflected the AHA's "Life's Simple 7" cardiovascular protective factors, such as nutrition, smoking cessation, and physical activity, and they further adapted the model by adding wellbeing, access, and health equity. The additional focus on wellbeing was prompted by conversations with residents who identified the issue of trauma and its impact on cardiovascular health as a priority area. Their theory of change was that by strengthening these protective factors, the county would have fewer emergency department visits, hospitalizations, and deaths related to coronary heart disease, heart attack, stroke, and overall hypertensive diseases.

The SDACH formed a data and metrics workgroup to select population health measures for each of the protective factors by reviewing publicly available data – primarily from the California Health Interview Survey (CHIS) and the Behavioral Risk

Factor Surveillance Survey (BRFSS). A summary of the adult metrics are shown in **Figure 2.** The SDACH is asking the health care community and other sectors to keep these goals in mind as they develop or enhance their own programming related to cardiovascular health improvement.

Figure 2. San Diego Accountable Community for Health Priority Population Health Indicators for Adults

Priority Population Health Indicators - Adults ***Improve Priority Indicators by 20% by 2030***		
NUTRITION Percent of population with an income of 200% of poverty or less who have experienced food insecurity *(the focus of the North County Inland Nutrition Security Subcommittee)*	**WELLBEING** In general, your health is excellent, very good or good (BRFSS)	**PHYSICAL ACTIVITY & BMI** 1) Participated in any physical activity in the past month (BRFSS) 2) Percentage of adults in each BMI category: normal, overweight and obese (CHIS)
HYPERTENSION Told you have hypertension by a health professional (CHIS)	**CIGARETTE SMOKING** Frequency of cigarette smoking for those that have smoked at least 100 cigarettes in their lifetime (CHIS)	**DIABETES** Told you have diabetes by a health professional (BRFSS)
ACCESS Have a place you usually go when you are sick or need advice about your health (CHIS)	**EQUITY** Track existing dashboards and indicies, such as Live Well San Diego, AARP Livability Index, the Community Need Index and the California Healthy Places Index.	

Note: Baseline = 2011 for most indicators | SDACH also established indicators for children and adolescents. See their website at www.sdach.org for current metrics and additional details.

Population-level indicators and outcomes are summarized in **dashboards** on the SDACH.org website. Emergency room discharges, hospitalizations, and deaths are reported by race/ethnicity and region. The SDACH **Biannual Data Report** (2022), which focuses on cardiovascular health disparities, is also available on the website.

E. Wellness Fund & Sustainability

The original concept of the Wellness Fund assumed that payment reform was imminent nationally and in California and that widespread adoption of shared savings models would create an environment where payers invested in prevention activities and services that address health-related social needs. CACHI advanced the Wellness Fund concept anticipating that development of this infrastructure would help prepare ACHs for this environment. As a result of the 2016 election—just months after CACHI commenced—federal health policy in this regard slowed.

The Wellness Fund's Key Functions from the 2016 RFP:

- **Provide critical resources for the ACH infrastructure, including the backbone organization.**
- **Support ACH prevention and upstream interventions that are often under resourced.**

Value of the Wellness Fund

The purpose of the Wellness Fund is to act as a vehicle for attracting, braiding, and blending resources from a variety of organizations and sectors, in alignment with the goals, priorities, and strategies developed by the ACH. *The Wellness Fund was intended to extend the ACH principles of shared accountability and collective action into the management of resources.*

In theory, the Wellness Fund would be managed by an external organization or entity responsible for distributing funds based on savings accrued across ACH partners that could be reinvested into upstream efforts. Securing these financial investments from health plans, hospitals, and other health sector partners during the course of CACHI implementation turned out to be extremely challenging and not very realistic for many ACHs. Throughout the course of CACHI implementation, ACHs were encouraged to create a business or sustainability plan in parallel with Wellness Fund design. Part of the sustainability plan included developing the "business case" for maintaining the operational needs of the backbone organization and identifying potential funding sources and investment targets.

> ***"The Wellness Fund was intended to extend the ACH principles of shared accountability and collective action into the management of resources."***

Because of the myriad challenges associated with developing a sustainability plan, technical assistance around these issues was critical and appreciated. Technical assistance partners JSI and Social Impact Exchange helped grantees think through how to diversify their revenue

base and provided guidance on how to establish a wellness fund using various models. ACHs received technical assistance and support on developing the business case for the ACH and templates for creating a compelling but brief "pitch" to funders and health plans that included a specific request for funding support. ACHs communicated the value of the ACH to external audiences to engage new partners, communicate the impact of ACH activities to the community, and garner financial support.

Successes and Accomplishments

- **Partners are vital to financial sustainability of the ACH.** Local stakeholders are highly committed to the long-term sustainability of the ACH. Multiple grantees expressed confidence that partners are committed to ongoing collaboration around joint-funding proposals and participating in sustainability conversations. Leaders from various sectors look to the ACH and the backbone organization because of their ability to bring partners to the table to pursue funding opportunities, and to leverage the concept of the Wellness Fund and its infrastructure for resource distribution across the community. ACHs have nurtured a collaborative spirit among partners, and have made significant progress in aligning resources, advancing cross-sector strategies, and engaging new partners in the process.

- **The ACHs succeeded in securing additional funding from state and local funding sources, as well as philanthropy to sustain backbone operation and key programming.** By the end of the grant term, very few ACHs had an independent, externally administered and collaboratively governed Wellness Fund in place as originally conceptualized in the CACHI model. To be fair, establishing this kind of community Wellness Fund represents a very high bar. Statewide, shared savings arrangements between the health and social sectors have not spread as quickly as some anticipated, and there are relatively few working examples of local-level Wellness Funds, especially ones that support the kinds of broad and evolving portfolio of activities that several California ACHs now have. Imperial had an established Wellness Fund prior to CACHI grant funding, ESJ established one during the grant period, and Stockton has taken steps towards a housing-specific fund. Despite the absence of an external community fund in most cases and the challenges ACHs encountered attracting funding, nearly all CACHI sites managed to secure additional state and county grants, and philanthropic support to sustain backbone operations and key programming.

- **Shifting from Wellness Fund to Broader Sustainability.** Given the challenges (discussed below) establishing an independent, external Wellness Fund, CACHI shifted the approach to sustainability beyond establishing a designated fund to include a variety of sustainability considerations. Given the programmatic pivot during COVID, ACHs demonstrated their relevance by responding to community needs and taking on new health issues and priorities. The ability to pivot, respond, and expand to new issues was an important component in sustainability. Another key sustainability strategy for the ACHs is to align their activities with Medi-Cal priorities and other state programs such as CalAIM to solidify their role in bringing clinical and community stakeholders and decision-makers together to implement mutually reinforcing activities to achieve a common goal.

ACHs adopted a variety of funding strategies to sustain their activities, including:

- Contracting directly with health plans for established CHW Network and care management functions (San Diego, Fresno)
- Securing county funding to sustain ACH backbone functions (e.g., convener/facilitator role) (Sonoma, Humboldt, West Sacramento)
- Leveraging ACH success to secure state funding for ACEs Aware to create a trauma-informed network of care (Fresno, San Diego)
- Pursuing federal grant opportunities (San Gabriel Valley, Stockton)
- Creating a "membership" model for partner organizations to contribute to support sustainable backbone functions that benefit the ACH collaborative (Fresno)
- Partnering with local community foundations and hospital community benefit programs (Sonoma)

Examples

- **San Diego: Neighborhood Networks is a self-sustaining model for funding SDACH and CBOs through facilitating contracts with care plans. SDACH plans to leverage this infrastructure to continue work on building clinical-community linkages for ACEs-affected families.**
- **San Gabriel Valley: Healthy San Gabriel Valley and All in for Azusa focused on braiding resources and funding as a sustainable approach for the future; they have secured ongoing, annual commitments from City of Hope and Canyon City Foundation, funding from Kaiser Permanente Community Benefit, and successfully advocated for federal funding with the local congressional representative.**

Challenges

- **Insufficient capacity and expertise within the ACH and timeline to develop the Wellness Fund.** Several ACHs experienced challenges balancing Wellness Fund development, creating a broader sustainability plan, and implementing other ACH activities. Some sites felt establishing a Wellness Fund was premature and that their local coalitions needed to survive and mature through the COVID pandemic before creating a long-term financial sustainability plan. For some ACHs, the CACHI timeline for Wellness Fund development felt both "rushed" and "too ambitious" given the developmental stage of the ACHs in terms of stability of governance, partnerships, and rebound from the pandemic. One site stated, "the concept of the Wellness Fund and the input on how best to structure it feels useful, but it also feels premature and not a good fit for our community right now."

- **Perceived competition between community partners.** Several grantees expressed reluctance in setting up a wellness fund for the ACH due to the perception that they would be competing with community partners for the same funding. This fear was particularly true for ACH backbone organizations that were community-based nonprofits rather than county public health departments. Reinvent South Stockton Coalition considered, but never pursued 501c3 status because they did not want to be in competition for funding with community partners. Instead, many ACH backbone organizations chose to identify and broker joint-funding opportunities that could be shared across partners to foster trust and collaboration, which can be considered a key precondition to developing a Wellness Fund.

- **ACH geography poses sustainability challenges.** ACHs in rural areas and those working in smaller neighborhoods within large urban counties often had challenges amassing sufficient resources for either an independent Wellness Fund or long-term sustainability. Four ACHs (Boyle Heights, Stockton, San Gabriel Valley, San Diego) implemented ACH activities on a neighborhood scale in a large county or had a dual approach with local and countywide/regional strategies. Working with large county agencies and partners when implementing targeted, localized strategies was a challenge when thinking through funding requests of government entities, community foundations, health plans and hospital systems that may span a large geographic area. ACHs based in rural regions (e.g., Merced, Imperial, Lake, Humboldt) experience resource scarcity generally (human resources and funding), with limited options to generate and channel robust investments to a community health fund.

ACH Highlight | East San Jose Peace Partnership

The East San Jose Peace Partnership established their Wellness Fund relatively early during the CACHI grant period. A workgroup of Steering Committee members investigated options and made a recommendation for an external (non-county) entity to act as the Wellness Fund operator.

Initial contributions to the fund included $100,000 from the CACHI grant and $250,000 from the Santa Clara County Office of Re-Entry and they have since received funding from the Chan Zuckerberg Foundation, Silicon Valley Community Foundation, and other philanthropic organizations. The Peace partnership has used Wellness Fund resources to provide direct aid to community members and organizational partners during COVID and to support resident involvement.

During COVID, the East San Jose ACH relied on these flexible funds to provide resources to families in need. They provided financial support to families with economic and employment losses during COVID, all out of their Wellness Fund. Over $604,000 was distributed to over 730 East San Jose individuals and families.

SECTION 3 | ACH ACCOMPLISHMENTS: SYSTEMS CHANGE

At its core, CACHI is a systems change initiative aiming to transform and align norms, practices, and policies to improve health equity and long-term population health outcomes. Because systems change work is developmental, complex, and takes time, a key aspect of the evaluation was to track both progress toward and achievement of systems changes across the sites.

Understanding that systems change is a developmental and evolving process, the following section assesses the systems change progress and achievements of the CACHI sites using an adaptation of the BUILD Initiative framework (Equal Measure et al., 2019), which sorts out systems change precursors (enhanced knowledge, strengthened relationships, increased individual and organizational capacity, and meaningful community ownership) and their associated systems changes (transformed norms or ways of working, changes in organizational practice and policy, new or realigned funding, and supportive policy or regulation).

Throughout this section, we use this framework of precursors and systems changes to illustrate various ACH accomplishments:

Precursors Emerge as Indicators of Progress	
Enhanced knowledge, shifts in disposition and behaviors, and refined complex issue framing	**Strengthened champions and community ownership**
Strengthened relationships and increased alignment	**Increased individual and organizational capacity**
Systems Changes Build On and Reinforce Precursors	
Transformed norms and ways of working	**Strengthened champions and funding streams**
Organizational shifts and scaling that sustain practice and policy	**Implementation of supporting regulatory, legislative, and public policies**

Progress Towards Systems Change

Over the last five years, CACHI ACHs made demonstrable progress in solidifying the core ACH model elements necessary for creating the conditions for longer term systems changes. Sites also achieved systems changes that are necessary for reaching their end goals related to improved population health and health equity.

The work of the ACHs resulted in numerous systems changes that are both concrete accomplishments (e.g., launching initiatives that connect medical and social services or bringing new funding resources to the community), and less concrete, but equally important achievements (e.g., helping to spread trauma-informed care principles across settings). This section presents some of the most visible accomplishments of the thirteen CACHI ACHs.

Strengthening partnerships was a foundational precursor to systems change. From the beginning of the Initiative, sites recognized that establishing, expanding, and engaging in strong partnerships was foundational to building a well-functioning ACH and created the conditions for systems change.

Table 3 *(on the following page)* provides detail on the progress the ACHs made with organizational and community partnerships. Overall, partners reported that the ACHs experienced greater success in building organizational partnerships compared to partnerships with community residents and leaders, which improved over the course of the initiative, but remained an area for strengthening and improvement.

Respondents reported significant progress in key partner organizations getting involved, playing meaningful roles in decision-making, working collectively on behalf of the community, and committing resources to the ACH efforts. While respondents reported less progress in engaging community residents and leaders, it is significant that over a third (36%) of respondents reported increases in residents' sense of power to influence community change.

Table 3. Progress on organizational and community partnerships, 2021 CACHI Partner Survey (12 ACHs, N=141)

Topic and Question	A Lot of Progress/ Achieved		Little Progress/ Not started	
	N	%	N	%
Organizational Partnerships				
Key partner organizations are identified and integrated	128	91%	13	9%
Partner organizations play a meaningful role in decision-making	110	81%	25	19%
Partner organizations work together more effectively	103	77%	31	23%
Partner organizations act for the good of the community	98	73%	36	27%
Conflict among partner organizations is openly addressed and managed	62	70%	26	30%
Partner organizations commit resources (e.g., time, effort, funds) to ACH efforts	88	67%	44	33%
ACH helps to align resources and activities across organizations and sectors in our community	91	65%	48	35%
Partner organizations take responsibility for coordinating and implementing ACH work	78	61%	49	39%
ACH helps reduce duplication of efforts by forming linkages between organizations	75	58%	55	42%
Community Engagement and Partnerships				
ACH offers support and resources to encourage communities of color and/or other groups who ex-perience health disparities to participate	72	56%	56	44%
ACH makes events or meetings accessible to everyone	68	53%	61	47%
ACH routinely gathers community or resident feed-back on ACH activities and decisions	53	50%	53	50%
ACH engages residents who are representative of the community to inform its work	59	46%	69	54%
ACH explicitly involves residents or community members in decision-making	51	41%	73	59%
ACH helps increase residents' sense of power to change and influence their community	38	36%	68	64%

Using the Build Systems Change Framework, **Tables 4 and 5** provide a summary of some of the key areas in which the ACHs made progress in creating the precursors for and achieving systems change, as well as examples of ACH achievements in these areas. **Table 4** provides a high-level summary of how ACHs enhanced knowledge of community health priorities and activities, strengthened, and expanded collaborative working relationships across diverse partners, and built organizational and leadership capacity.

Table 4. ACH Systems Change Precursors

Enhanced Knowledge	
» ACHs made racial equity more explicitly part of their aims, work, and operations, including community engagement approaches, data collection, and reporting practices to examine disparities.	
» Developed a shared language for addressing health equity across system partners and the community.	
» Increased knowledge and expanded training and adoption of trauma-informed care or service principles.	
» Used data in new ways to better understand and prioritize community health needs and priorities.	
» Used data to improve communication, transparency, and trust with community stakeholders through public facing dashboards and narratives on programmatic success.	
Site Examples	» ACHs parlayed their trauma-informed care and community-clinical linkages work into successful ACES Aware grants to screen and address trauma among Medi-Cal members.
	» Humboldt Community Health Partnership used an equity lens in the design process for the CIE.
Quote	*"Values of health equity and racial justice are part of our organizational culture now. It's the first time we started a technical process (CIE) with an equity lens."* **—Humboldt ACH**
Strengthened Partnerships	
» Deepened relationships and expanded cross-sector partnerships to build strong, adaptable coalitions that bring value to their key stakeholders.	
» Aligned activities across organizations, added new and diverse partners to community health improvement table, increased trust, and helped create a culture of collaborative work.	
» Leveraged collaborative working relationships to quickly convene and generate solutions during the COVID pandemic. ACH partners were able to align resources, increase distribution of information using a common message, while expanding testing and vaccines in hardest to reach communities.	
Site Examples	» Healthy San Gabriel Valley ACH completed a network analysis of the social connectedness between partners to visualize the network relationships, provide insights about the ways they work together, identify opportunities for continued network development, and demonstrate the impact of their collective efforts to funders and stakeholders.
	» **West Sacramento ACH partners worked together to distribute monthly food deliveries to housing complexes and share COVID resources including vaccine/testing outreach in under-resourced neighborhoods.**
Quote	*"The backbone has become the very trusted neutral organization that helps tie us all together and move us forward together toward the common goals."* **—San Diego ACH**

Table 4. ACH Systems Change Precursors *(Continued)*

Individual and Organizational Capacity	
» ACHs recognized as a central coordinating and convening table that can triage community issues and work on system-level strategies.	
» Established distributed leadership structure across partners and work groups to engage diverse partners and community leaders.	
» Leveraged technology to support community-clinical linkages to track referral connections and service access through a shared care coordination platform and created Community Information Exchanges (CIE) to facilitate cross-sector referral and coordination.	
» Invested in resident/community member leadership development training, funded "community connectors" to conduct outreach and education, and awarded community resident "mini grants" to further engagement in community health improvement projects and activities.	
» Created new opportunities for community-based organizations and traditional health system stakeholders to partner on interventions that impact the community.	
» Established and expanded community-clinical linkage projects aimed at improving patients' access to preventive and chronic care services, promoting healthy behaviors, and filling gaps in much needed services.	
» Community health workers (CHWs) leveraged knowledge of communities they serve to bridge the divide between the community and institutions, facilitate access to clinical and SDoH services, and improve the quality and cultural competence of service delivery.	
Site Examples	» ACHs expanded health system and community-level screening for a range of conditions including cardiovascular disease (Sonoma, San Diego), diabetes (Merced), food security (San Diego), and asthma (Imperial), among others. ACHs serve as the linkage point between health plans and the community-based organizations that employ community health workers.
	» Fresno County ACEs Aware Trauma Informed Network of Care created a screening, referral, and response process to support families who are at risk of experiencing negative mental and physical health outcomes from ACEs. As of early 2022, 40 organizations were trained in ACEs science and toxic stress, 35 organizations were trained to use the referral platform, and 25 community health were workers hired and trained.
Quote	*"Because of our ACH work, there is better coordination and collaboration between medical care, social care and behavioral health care organizations in our community."* **—Humboldt ACH**

Achievement of Systems Changes

Table 5 presents systems changes achieved by ACHs related to transformed norms, including commitment to equity, changes in organizational practices within and across partners, securing new and sustainable funding mechanisms, and policy changes achieved.

Table 5. Systems Changes Achieved

Transformed Norms	
» Incorporated equity explicitly into their vision and purpose, priorities, community engagement practices, data analytics, and stakeholder composition.	
» Included diverse voices and those facing health disparities into community health discussions and strategic planning (e.g., CHNA process post COVID) to integrate a diversity, equity and inclu-sion lens and authentic community engagement practices into ACH work.	
» Connected the needs of marginalized communities to solutions generated by health care organizations and systems.	
» Created trust among their community partners to move from competition for resources to collaboration around shared goals and activities.	
» Stakeholders engaged and aligned with the ACH and backbone organization because of their ability to bring partners to the table to pursue joint funding opportunities and distribute resources across the community.	
Site Examples	» FCHIP Trauma and Resilience Network (TRN) workgroup serves as a guiding force in all FCHIP's work. Trauma-informed practices are at the root of every project FCHIP takes on or collaborates in.
	» Humboldt Community Health Partnership used an equity lens in the design process for the CIE.
Quote	*"The fact that we did our groundwork, developed a governance structure, developed values, developed a vision, had diverse set of partners on the table – really set us up well when COVID hit. In our first meeting we had a problem reaching the Russian population, people had solutions in a minute – offering translators, offering services via meals, wasn't about ego or money, but working in a collective way—this continued through COVID—people showing up differently and working in a different manner."* **—West Sacramento ACH**
Organizational Shifts in Practice & Policy	
» Identified gaps and created new community-clinical interventions that spanned health and community sectors and served to enhance service referral, linkage and care coordination spanning a variety of health and social issues.	
» Neighborhood networks of CHWs address workforce issues and create linkage between health plans, CBOs, and community members. CHWs offer families the opportunity to be decision-makers in their health outcomes by identifying risks and connecting them the appropriate social, mental health, and medical services resources to remove barriers to health.	
» ACH cross-sector collaboration helped organizations work together in new ways, letting go of habitual turf and boundaries to respond rapidly to community needs and improve coordination.	
Site Examples	» Humboldt engaged in comprehensive system discovery efforts in developing the County's Community Information Exchange. After four years of research, discovery, financing, co-design, and partner engagement, the North Coast Care Connect went live on February 1st, 2022.
	» As part of building the CHW Neighborhood Networks, San Diego ACH revised contracts with Medi-Cal managed care health plans, modified billing procedures, purchased a new online technology care management platform, and retrained staff from all community-based organization partners.
Quote	*"There's an overwhelming emphasis on addressing health disparities, going upstream, addressing social needs, and integrating behavioral health. It's a big shift from when everything was all clinical."* **—Lake County ACH**

Table 5. Systems Changes Achieved *(Continued)*

New or Re-Aligned Funding	
» Increased financial resources for targeted neighborhoods and identified resident priorities and distributed funds to community partners during COVID pandemic.	
» ACH partners worked collaboratively to secure joint-funding opportunities and secure resources that benefit an array of community partners.	
» Created reimbursement mechanisms for community health workers and compensated community residents for participation in various ACH activities.	
Site Examples	» New funding arrangements (e.g. contracts between managed care and community-based organizations via San Diego's Neighborhood Networks, or health plan investment in transitional housing in Lake County.)
	» West Sacramento ACH partnered with the City of West Sacramento to obtain approximately $10,000,000 for park/recreation improvements. Increased financial resources for targeted neighborhoods and identified resident priorities including approximately $10,000,000 for park/recreation improvements.
Quotes	*"Over the course of 2021, PEACE organized consecutive fund distributions, and gave out over $604,000 to over 730 East San Jose individuals and families. The key to our success was the reputation we have in the community as a trusted partner, and the network of relationships we were able to activate in a time of crisis. We were seen as the best organization to get the money out to those in need in a simple, fast, and equitable manner."* **—East San Jose ACH**
	"The ACH has effectively established a collective to address the opportunities and needs under CalAIM that maximizes the amount of funding directed to client experiences and outcomes, while also building capacity of community health workers and local nonprofits. Managed care companies and other funders get more for their money and a higher quality of care." **—San Diego ACH**
Supportive Policy and Advocacy	
» Served as a strong, credible advocate for community interests and worked with local leaders to secure projects/benefits for current and future residents e.g., local hire, affordable housing, health services, etc.).	
» Identified and shaped policy recommendations impacting communities.	
Site Examples	» South Stockton engaged with the city and community leaders to successfully launch the Parks Activation & Beautification initiative to revitalize Williams Brotherhood Park, the only park of significant size serving 50,000 residents in Southeast Stockton.
	» West Sacramento ACH educated City Council members, which led to a city-side flavored tobacco ban and expanded relationship with local government leading to planning for a city racial equity policy.

Table 5. Systems Changes Achieved *(Continued)*

Quotes	*"All our workgroups and committees have representation of all our stakeholders. Although everyone has a seat at the table, the community feedback and needs are given priority over everything else. For example, community feedback informed the use of a housing project in the area that also included a park. The design, layout, and uses of this park and project were decided by a community committee based on the needs of the residents surrounding the development project."* **—Boyle Heights ACH**
	"A combination of data and resident input was used to identify the upstream risk factors to address first (access to healthy food, walkability, and social connectedness)...When Covid hit, an additional focus on access to COVID resources emerged. The ACH coordinated direct outreach regarding Census, COVID testing and vaccinations in the lowest income neighborhoods and collaborated on food dissemination as demand multiplied. The ACH organizations (many that never directly engaged residents before) valued the resident connections and the community-based organizations that were able to make this engagement happen. Currently, we are in conversations with Mayor Guerrero about adopting an equity plan for West Sacramento." **—West Sacramento ACH**
	"There's an overwhelming emphasis on addressing health disparities, going upstream, addressing social needs, and integrating behavioral health. It's a big shift from when everything was all clinical." **—San Diego ACH**

The evidence and examples presented in **Tables 4 and 5** shed light into what it takes for the ACHs to achieve long-term, sustainable, systems transformation by creating the intention and momentum to tackle entrenched systems that reinforce inequities and lead to poor outcomes.

The precursors shown in **Table 4** create the capacity and build the community muscle for advancing systems changes as described in **Table 5:** adopt new norms, ways of doing business, change regulations and policies, and redirect and procure resources to support health and equity.

As the ACHs continue to accomplish systems changes, there is increasing confidence within the communities that sustained improvements in health and equity are possible.

SECTION 4 | LESSONS LEARNED FROM CACHI IMPLEMENTATION

Over the course of CACHI implementation, there were several important lessons learned that can help inform future ACH implementation as the model scales and spreads to other geographies within California and nationally. These include:

1. **A dedicated, skilled, and well-compensated backbone organization is critical to ACH effectiveness and success.** ACH backbone agencies provide critical infrastructure and are often responsible for conducting many of the "integrative activities"[4] of an ACH like convening stakeholders, facilitating the process of identifying priorities, implementing improvement plans, tracking data, and securing financing.

   ACH backbone staff are often called upon to negotiate conflict between previously disconnected entities and help build trust across sectors and stakeholders that have not shared power or organized around a common goal in the past. This requires experienced leadership, thoughtful and consistent communication, and the ability to maintain focus on the broader community health goals of the ACH. Without a dedicated backbone agency and staff to drive the work, members representing partner organizations are at risk of being pulled away by the needs of their own organizations.

2. **The POI gives the ACH a recognizable purpose, plan, and identity.** The Portfolio of Interventions is what sets the CACHI model apart from other multi-sector collaboratives. Two things distinguish a true POI from a simple list of activities or interventions: (1) connection of the POI to a clearly articulated goal, one that is focused enough to lend coherence to what is and is not included in the portfolio; and (2) material coordination or alignment of the interventions so they have the potential for greater impact. Those things in turn make it easier to engage the community, attract partners and resources, track effectiveness, and decline opportunities that do not fit.

   Robust POIs are comprised of meaningful strategies and activities, both existing and new, that reflect community needs and priorities, and are aligned to collective goals. Developing the POI should be done collaboratively with a wide range of cross-sector partners, even if the process takes time.

3. **Community member engagement in ACH efforts is essential to advance equity and achieve collective accountability.** Active engagement of residents and community members helps steer ACH decisions and POI activities toward community needs and priorities, rather than issues or solutions that institutions might identify.

4 | More information available here: rethinkhealth.org/wp-content/uploads/2019/09/RTH-BTG_Appendix1_Digital.pdf

Successful community engagement requires focused effort to make the ACH structure (and language) more accessible and inclusive, ongoing support for community leaders' time, and ample accommodations for community members to facilitate consistent involvement, including compensation. Many public, private, and community organizations are still grappling with how their structures and practices support or obstruct equitable partnerships with community members. ACHs and their partners broadly see this is a priority and are continuing to learn how to include them authentically.

4. **ACHs that have access to data and clear measurement strategies are better able to prioritize their work to areas of greatest need, demonstrate results, and communicate successes.** The process of identifying population health outcomes and indicators helps multi-sector partners envision the definition of health improvement in the long term. Data discussions among ACH partners increased awareness of the importance of equity and collecting and reporting data by race/ethnicity and region, to ensure an understanding of health disparities.

   Capturing data on a dashboard is a specialized skill set, and one that may require technical assistance from a consultant. Translating data into a compelling narrative about the impact of this work enables ACH stakeholders to make their case to residents, possible funders, or potential new partners.

5. **Financial sustainability of the ACH depends on partnerships, creative and joint problem solving, and aligning to local and state initiatives and priorities.** Leaders from various sectors look to the ACH and the backbone organization because of their ability to bring partners to the table to pursue joint funding opportunities, and to leverage its infrastructure for resource distribution across the community. ACHs have nurtured collaboration among partners, and have made significant progress in aligning resources, advancing cross-sector strategies, and engaging new partners in the process.

   ACHs are well-positioned to support health sector partners with implementation of statewide initiatives and facilitate clinical-community linkages. In certain cases, this has led to the creation of new business ventures and contractual relationships to support this function and role of the backbone organization. There is growing acknowledgement that health sector partners, including health plans, play a vital role in ongoing financial investment in improving community health. Supporting ACH infrastructure is a concrete way for health sector partners to demonstrate they are "part of the community" by investing in enhanced programs that support prevention and health-related social needs and enhance service access and navigation.

6. **Transformational changes in CACHI are complex and technical assistance (TA) support was essential in addressing the many interdependencies that emerge in implementing the key model elements.** ACH components are connected and progress or challenges in one area impacts progress in others. Many of the model elements are inter-dependent and require simultaneous attention, rather than pursuing a more linear implementation path.

   ACHs are incorporating significant changes across multiple domains, which may lead to delays in reaching certain milestones across all components. Because of this dynamic nature of ACH implementation, outside technical assistance was essential in supporting POI development, communication of progress and achievements to the community, and financial sustainability. The benefit of long-term investment in this work is that ACH communities will be poised to be advance sustainable, cross-sector systems change.

7. **The historical context of partnerships and communities matter, and shapes and influences all aspect of ACH development and implementation.** The best way to understand the context and realities of a given ACH today is to understand the historical context of partnerships and community needs and challenges. There is ample evidence that CACHI facilitated trust and collaboration and sparked new ways of thinking and doing business across partners, which led to progress towards real systems change.

   ACH successes—and most persistent barriers—are often a function of well-established and deeply ingrained approaches to collaboration, historical relationships within communities, power dynamics among partners and willingness to adapt to adversity and presence of resources, either scarcity or surplus. ACHs differ from each other in many ways due to their unique contexts, which should be understood by funders. At the same time, ACHs also found it tremendously valuable to learn from each other.

8. **Communication and messaging about CACHI to external audiences is a profoundly significant endeavor.** Given the complex and dynamic nature of the ACH model, along with the involvement of multiple sectors that span healthcare and community sectors, creating clear communication materials and messaging campaigns about "what the ACH is" have been an important factor in ACH visibility, success, and sustainability.

   ACH structure is multi-layered and complex, and the language used to describe the model created confusion for many stakeholders and community members. The pace of progress made it difficult to "market" tangible changes and benefit to the community. As sites made progress responding to community priorities, especially during the COVID pandemic, and securing funding to address community needs it became easier to convey the value of the ACH to community stakeholders.

Technical assistance from external consultants was instrumental in building this skill and capacity within ACH communities.

9. **Turnover of key leaders and partners is inevitable and offers opportunities for building resiliency and innovation in the long run.** Nearly all the CACHI sites experienced turnover in leadership or key partners over the course of implementation. Although in some cases these changes lead to setbacks for the sites, in many cases, these changes created space for new perspectives, experiences, and partnerships to continue, evolve, and advance the ACH work.

10. **Community stewardship and collective accountability are preconditions to lasting systems change.** ACHs that experienced the most growth and success embraced the concept of community stewardship and examined what role and responsibility each member/partner of the ACH has in advancing the goals of the ACH and improving community health.

    One grantee stakeholder stated, "The word 'stewardship' forces you to ask, 'what is my responsibility, what more can my organization do, given its role in the community?'" Systems change is possible when ACH organizational partners elevate above their individual interests and recognize the opportunity (and responsibility) to do more for the community when vision, resources, and capacities are aligned for a common goal. Shared values are important but must be coupled with shared action.

SECTION 5 | CONCLUSION

Overall, CACHI demonstrated that the ACH model has significant potential to bring value to communities by promoting collaboration, equity, and sustainability in efforts to improve health outcomes. The original CACHI theory of change was shaped significantly by the policy context in 2015-16 when the Federal government was moving toward payment reform. The ACH was conceptualized as a pathway for creating a transformed health system to facilitate this reform.

With the 2016 election, the focus of CACHI shifted to addressing issues of equity and community health through collective action. Over the course of implementation, community ecosystems were disrupted and impacted by political unrest, a global pandemic, environmental disasters related to climate change, and various other local, national, and global challenges. In this context, the ACH has proven to be resilient and effective in enabling the necessary cross-sector collaborations required to advance toward addressing health inequities and improving community health.

In 2022, the State legislature recognized the achievements and promise of CACHI by allocating $15 million to scale and spread ACHs in more communities across California with oversight by the CA Department of Public Health. With additional support from The California Endowment, Blue Shield of California Foundation, and The California Wellness Foundation, a total of 37 (13 original and 24 new) ACHs will receive 30 months of funding starting July 1, 2023 to further build and sustain the ACH infrastructure locally by aligning with state initiatives to focus their collaborative work. The goal is to demonstrate the value ACHs can play in the local implementation and impact of state initiatives such as Integrating Children and Youth Behavioral Health, Partnering with Managed Care Plans to Reduce Health Disparities, Strengthening Community Resilience, and Coordinating Health Workforce Needs.

SECTION 6 | REFERENCES

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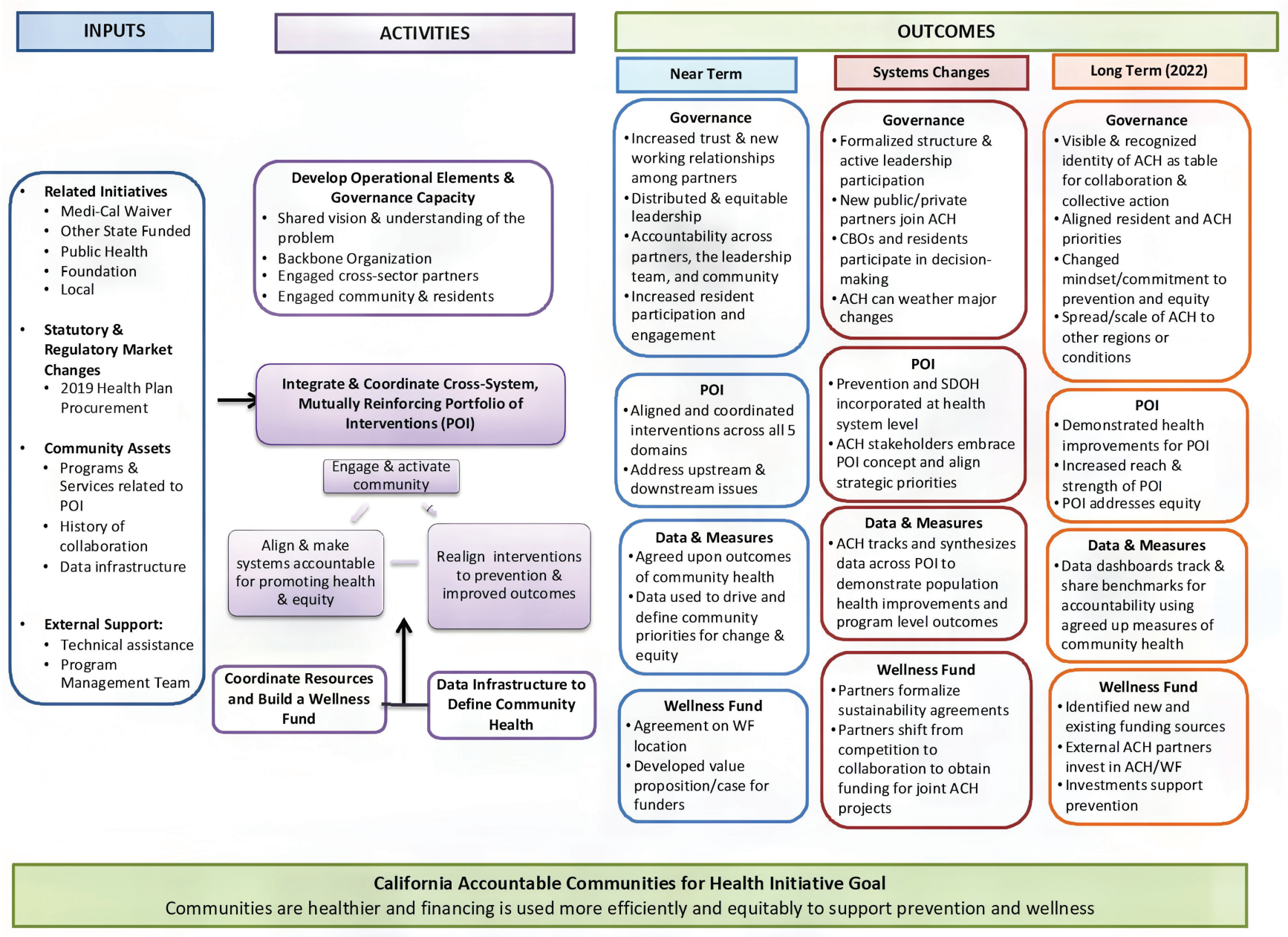
SECTION 7 | APPENDICES

Appendix 1: CACHI Initiative-Level Logic Model, January 2019



Appendix 2: Overview of ACH Focus Areas

ACH Name	Backbone	Backbone Type	Geography	Target Condition	Strategies
Boyle Heights Health Innovation Community Partnership	The Wellness Center at LAC & USC Medical Center Foundation	Health System/ Foundation	Boyle Heights Neighborhood	**TRAUMA/COMMUNITY RESILIENCE**	Screening and assessment; education and de-stigmatization; access to care
East San Jose PEACE Partnership	Santa Clara Public Health Department	Public Health Department	East San Jose	**TRAUMA/VIOLENCE PREVENTION**	IPV education and screening; affordable housing; anti-displacement; youth leadership
Fresno Community Health Improvement Partnership	Fresno Metro Ministry	Nonprofit Organization	Fresno	**TRAUMA INFORMED NUTRITION/FOOD INSECURITY**	Access to healthy food; trauma-informed training
Humboldt Community Health Trust	North Cost Health Improvement and information Network	Nonprofit Organization	Humboldt County	**SUBSTANCE USE DISORDER**	Cross-sector information and data sharing; SUD screening and treatment
Imperial County Accountable Community of Health	Imperial County Public Health Department	Public Health Department	Imperial County	**ASTHMA**	Clinical-community linkages; asthma education; community leadership training; ACES screening
Hope Rising Lake County	Adventist Health Clear Lake	Hospital/ Health System	Lake County	**HOMELESSNESS/ SUBSTANCE USE DISORDER**	Transitional housing and support; Substance use treatment and prevention
All Children Thrive Long Beach	City of Long Beach Public Health Dept	Public Health Department	Long Beach	**CHILDREN'S HEALTH AND WELL-BEING**	Early education; access to services; community leadership; economic
Merced County All-In for Health	County of Merced	Public Health Department	Merced County	**CHRONIC DISEASES, FOOD SECURITY, ACCESS TO CARE**	Governance enhancement, diabetes prevention (pre-COVID)

Appendix 2: Overview of ACH Focus Areas *(Continued)*

ACH Name	Backbone	Backbone Type	Geography	Target Condition	Strategies
San Diego Accountable Community for Health	San Diego Wellness Collaborative	Nonprofit Organization	San Diego County; North Inland San Diego	**CARDIOVASCULAR DISEASE**	Nutrition services; Neighborhood Networks; ACEs Network of Care development
Healthy San Gabriel Valley	YWCA of San Gabriel Valley	Nonprofit Organization	San Gabriel Valley and City of Azusa	**VIOLENCE PREVENTION/ COMMUNITY RESILIENCE**	Health promotion; education; workforce development; clinical services and linkages to care
Health Action Sonoma County	Ceres Community Project	Nonprofit Organization	Sonoma County	**CARDIOVASCULAR DISEASE**	Prevention and management programs for CVD risk factors; community-based screening and referral
Reinvent South Stockton	Reinvent South Stockton Coalition	Nonprofit Organization	South Stockton	**TRAUMA, HEALTHY LIVES, EARLY CHILDHOOD EDUCATION, WORKFORCE**	Violence prevention; education; workforce development, resident leadership; neighborhood transformation
West Sacramento Accountable Community for Health	Health Education Council	Nonprofit Organization	West Sacramento	**HEALTH INEQUITIES, HEART DISEASE, COVID-19**	Food security; park improvements; COVID response

Appendix 3: ACH Overviews

All Children Thrive Long Beach (ACT)

Backbone Organization: City of Long Beach Public Health Department (Public Health Department)

Geography: Long Beach

CACHI Target Condition: Children's health and well-being

Strategies: Early education; access to services; community leadership; economic well-being

ACT Role as Reflected in Backbone Interviews and Final Report Materials: ACT has successfully engaged and retained a variety of partners over the past five years and has achieved cultural and systems level changes in the community care landscape. They facilitate cross-sector sharing of present needs, resources, and best practices and ensure a broader range of partners are able to effectively serve the needs of young children. Through establishing a collaborative with a holistic approach to early childhood care, they have diversified the funding opportunities available to partners.

Primary Organizational Partners: City of Long Beach, Long Beach Department of Health and Human Services, The Guidance Center, Long Beach Unified School District, Zero to Three, The Children's Clinic, Long Beach Forward, Mayor's Fund for Education, Long Beach Public Library

Key Strengths/Assets as Identified by ACH: Longevity of commitment of partners, successfully cultivated collaborative spirit among partners, effectively aligned efforts and vision across sectors, brought together previously siloed partners, broadened and improved referral network (e.g. partners now feel more equipped to refer effectively since they are clearer on each agency's role and capacity), earned community trust through resident engagement, formulated solutions based on data, expanded data sharing efforts, and maintained clear direction with 5-year POI.

Boyle Heights Health Innovation Community Partnership

Backbone Organization: The Wellness Center at LAC & USC Medical Center Foundation (Health System/Foundation)

Geography: Boyle Heights Neighborhood

CACHI Target Condition: Trauma/Community Resilience

Strategies: Screening and assessment; education and de-stigmatization of mental illness; access to care

BHHICP Role as Reflected in Backbone Interviews and Final Report Materials: BHHICP is wide in its focus, bringing together stakeholders around a variety of issues affecting the community to find and implement collaborative solutions, primarily in the areas of housing and care expansion, including programs to address early childhood trauma. They have successfully impacted development projects in and around LAC+USC Medical Center and USC Health Sciences Campus including Boyle Heights, Lincoln Heights, East LA and North East LA and informed best practices for future development in the county as well as produced policy recommendations. Through empowering community leadership and involvement and through convening disparate sectors, including partners outside of HICP, they have been able to increase both trust and efficiency while producing measurable outcomes around community stability and resiliency.

Primary Organizational Partners: HICP currently has over 60 members which include CBOs, government agencies, community members, small businesses, and more. HICP founding partners are Alma Family Services, Barrio Planners, Bravo Medical Magnet School, Cal State LA, Central City Association, Clinica Romero, East Los Angeles College, East Los Angeles Community Corporation, Eastside LEADS, El Arca, East LA Women's Center, Exodus Recovery, Grifols Biologicals, Hillside Village, Homeboy Industries, Inner City Struggle, Jovenes Inc, JWCH Institute, LA County CEO Office, LA County Department of Mental Health, LA County Dept of Public Health, LA County Dept of Public Works, LA County Dept of Workforce Development, LA County First District Office of Supervisor Hilda Solis, LA County Probation Dept, LA Latino Chamber of Commerce & C1P Solutions, LA Care Health Plan, LA Neighborhood Land Trust and more. They also collaborate and share information with the San Diego ACH.

Key Strengths/Assets as Identified by ACH: Able to effectively bring different organizations and stakeholders together, provides Spanish translations for all materials and meetings, encourages and facilitates information and resource sharing between agencies, builds community leadership, resilience, and collaboration.

East San Jose PEACE Partnership

Backbone Organization: Santa Clara Public Health Department (Public Health Department)

Geography: East San Jose

CACHI Target Condition: Trauma/Violence Prevention

Strategies: IPV education and screening; affordable housing; anti-displacement; youth leadership

ESJ PEACE Role as Reflected in Backbone Interviews and Final Report Materials: PEACE operates with a strong equity lens, centering projects that will improve the health and wellbeing of marginalized residents, such as combatting lead exposure and increasing city funding for underserved children and families. They facilitate community dialogue around responding to and preventing violence, including police violence and violence around the country. By facilitating strong working relationships between residents and a variety of agencies and organizations, PEACE assists the community in building and implementing a unified, equity-oriented approach to violence and trauma prevention.

Primary Organizational Partners: Alum Rock-Santa Clara St. Business Association, Alum Rock Counseling Center, Alum Rock School District, Asian Americans for Community Involvement, Catholic Charities of Santa Clara County: Franklin-McKinley Children's Initiative, City of San Jose City Manager's Office, City of San Jose Mayor's Gang Prevention Task Force, City of San Jose Housing Department and City of San Jose Parks, Recreation & Neighborhood Services, Community Health Partnership, District 5 United Neighborhood Group (Lyndale), East Side Union High School District, First 5 of Santa Clara County, Foothill Community Health Clinics, The Health Trust, National Compadres Network, Next Door Solutions to Domestic Violence, People Acting in Community Together (PACT), Santa Clara County District Attorney's Office, Santa Clara County Probation Department, Santa Clara County Parks and Recreation Commission, Santa Clara County Public Health Santa Clara Valley Health & Hospital System, Valley Health Plan Valley Medical Center, Somos Mayfair, Valley Medical Center Foundation, and Youth Connections Foundation.

Key Strengths/Assets as Identified by ACH: Centers community trust building and transparency effectively in their work, provides Spanish translation, financially supports community driven initiatives, facilitates collaboration between disparate sectors, maintains strong racial equity focus, Public Health in backbone role supports stability and efficiency.

Fresno Community Health Improvement Partnership

Backbone Organization: Fresno Metro Ministry (Community Non-Profit)

Geography: Fresno County

CACHI Target Condition: Trauma Informed Nutrition/Food Insecurity

Strategies: Access to healthy food; trauma-informed training

FCHIP Role as Reflected in Backbone Interviews and Final Report Materials: FCHIP Leaders and Partners are prioritizing a resilience based trauma-informed approach in addressing both protective and risk factors related to trauma. Assuring and building resilience is a community condition that touches each social determinant of health including access to healthy food. FCHIP has the capacity and the relationships with dedicated passionate cross-sector partners to garner joint action around these key issues through a racial equity lens and by authentically engaging the community.

Primary Organizational Partners: CalViva health plan, Department of Public Health, Fresno Metro Ministry, Trauma & Resilience Network, hospitals and community-based organizations.

Key Strengths/Assets as Identified by ACH: Strong governance structure with distributed leadership, commitment to diversity, equity and inclusion, creates synergy and alignment between health care partners and CBOs to educate, share resources and leverage collaborative funding opportunities.

Health Action of Sonoma County

Note: In February 2022, the Health Action Council voted to transition Health Action to an independent nonprofit. This new entity—temporarily known as Health Action 2.0 — is working to hire Backbone staff and will likely have some different focus areas than the previous iteration. The information below describes Health Action as it was during the CACHI funding period.

Backbone Organization: Sonoma County Public Health (Public Health Department)

Geography: Sonoma County

CACHI Target Condition: Cardiovascular Disease

Strategies: Prevention and management programs for cardiovascular disease risk factors; community-based screening and referral

HA Role as Reflected in Backbone Interviews and Final Report Materials: Health Action was formed as an advisory council to the Sonoma Board of Supervisors, though is currently in the process of separating from the county with the launch of Health Action 2.0. HA 2.0 will continue HA's commitment to authentic community engagement, prioritizing equity and marginalized communities when crafting and implementing solutions, to addressing cardiovascular health and community health and wellbeing in Sonoma County. HA 2.0 intends to be data driven and to spearhead and coordinate community information efforts. They aim to actively shift Sonoma County's systems toward community leadership by breaking down the practices that marginalized community voice.

Primary Organizational Partners: Over 150 organizations that represent the education, health care, philanthropy, government, business, and nonprofit sectors are involved in the work of Health Action. Some of these partners are West County Health Centers, Sonoma County Human Services Department, Ceres Community Project, Center for Well-Being, Santa Rosa Community Health, Kaiser Permanente Santa Rosa, St. Joseph Health Medical Group, Petaluma Health Center, Community Foundation of Sonoma County, and Sonoma County Office of Education.

Key Strengths/Assets as Identified by ACH: Organizational resiliency (successful planning and implementation of separation from county), well established presence in the service landscape with high levels of engagement and buy in from partners, strong equity focus, ability to bring together grassroots and systems level strategies, clear POI and outcome tracking, data driven.

Healthy San Gabriel Valley/All in for Azusa

Backbone Organization: YMCA of San Gabriel Valley (Nonprofit Organization)

Geography: San Gabriel Valley and City of Azusa

CACHI Target Condition: Violence Prevention/Community Resilience

Strategies: Health promotion; education; workforce development; clinical services and linkages to care

HSGV Role as Reflected in Backbone Interviews and Final Report Materials: HSGV is a multi-sector collaborative over a decade old that is focused on improving the health and overall wellbeing of San Gabriel Valley residents with particular focus on the City of Azusa through the All in for Azusa initiative. AIFA brings together efforts around health promotion and communication, education and economic/ workforce development, clinical services and linkages to care, social participation and community programs, and infrastructure and transportation to create a holistic approach to addressing community health needs. The YWCA-SGV backbone has long been involved in multi-sector work and leads with experience and a solid foundation in the community.

Primary Organizational Partners: Azusa Pacific University; City of Azusa; City of Hope; Center for Non Profit Management; East Valley Community Health Center; Emanate Health (formerly Citrus Valley Health Partners); First Christian Church; Kaiser Permanente Baldwin Park; Los Angeles County Department of Public Health; Los Angeles County Department of Mental Health; San Gabriel Valley Consortium on Homelessness; San Gabriel Valley Economic Partnership; and YWCA-San Gabriel Valley. The HSGV Design Team is comprised of representatives from YWCA-SGV, the City of Azusa, LA County Department of Public Health, the Counseling Center Azusa Pacific University, and City of Hope.

Key Strengths/Assets as Identified by ACH: Found innovative ways to generate sustainable income for partners, effectively disseminated SDOH information and its implications to a variety of partners who did not previously have SDOH on their radar, engaged a variety of key stakeholders in community leadership positions through nurturing individual relationships over time, effective in translating the work to residents, able to effectively rally partners to reach goals (e.g. securing over half a million dollars for the Azusa Teen and Family Center), strong backbone organization.

Hope Rising Lake County

Backbone Organization: Hope Rising Lake County (nonprofit organization)

Geography: Lake County

CACHI Target Condition: Homelessness, Substance Use Disorders

Strategies: Transitional housing and support; substance use treatment and prevention

Hope Rising Role as Reflected in Backbone Interviews and Final Report Materials: Hope Rising is a 501c(3) that convenes county leaders to mobilize around tackling homelessness, substance abuse, and general community wellness in Lake County. They provide project management support, distribute funds, and facilitate collaboration with the objective of strengthening community partnerships. They are also at the center of the County CHNA/CHIP effort. They launched the Hope Center, a 20 bed transitional housing center, and track its impact measurements closely.

Primary Organizational Partners: Governing Board members represent Lake County Office of Education, Lake County Department of Social Services, Partnership Health Plan, Sutter Health Lakeside, Adventist Health Clear Lake, Lake County Health Services, Redwood Community Services, County of Lake Board of Supervisors, County of Lake Behavioral Health Services, North Coast Opportunities, Lake Family Resource Center, MCHC Health Centers, and Woodland Community College.

Key Strengths/Assets as Identified by ACH: Organizational resiliency, gained trust in convener role, clear organizational and meeting structures resulting from 501c(3) status.

Humboldt Community Health Trust

Backbone Organization: North Coast Health Improvement and Information Network (Nonprofit Organization)

Geography: Humboldt County

CACHI Target Condition: Substance Use Disorder

Strategies: Cross-sector information and data sharing; SUD screening and treatment

HCHT PEACE Role as Reflected in Backbone Interviews and Final Report Materials: Functions as a community convener and facilitator of collaborative work in a county that was previously extremely siloed, thus reducing duplication and increasing efficiency. They began with an SUD focus but have evolved to focus on system level strategies that impact a variety of need areas. HCHT elevates equity concepts in community and systems work. To break down silos, they have focused on building infrastructure to support information and resource exchange and improve referrals with research, CIE work, and the launch of North Coast Care Connect and Activate Care for care coordination. It helps identify and fill care gaps and educates partners about a broad range of SUD topics to find and implement innovative upstream solutions, earning HCHT the reputation of a community care leader.

Primary Organizational Partners: The Governance Committee is composed of 17 members: DHHS Mental Health, Humboldt County Board of Supervisors, Open Door Community Health, First 5 Humboldt, Yurok Tribe, St Joseph Health, Partnership Health Plan, DHHS Public Health, DHHS Behavioral Health, DHHS Directors, McKinleyville Family Resource Centers, California Center for Rural Policy, Humboldt IPA, Transition Aged Youth Program, and community members.

Key Strengths/Assets as Identified by ACH: Ability to hone in on identifying and leveraging available resources and community capacity, has brought new partners into collaboration such as the cannabis industry and Native leaders, has proven to partners and residents that such collaborative work is possible and effective, able to effectively triage community issues and work to create systems-level changes.

Imperial County Accountable Community of Health (ICAH)

Backbone Organization: Imperial County Public Health Department (Public Health Department)

Geography: Imperial County

Target Condition: Asthma

Strategies: Clinical-community linkages; asthma education; community leadership training; ACES screening

ICACH Role: ICACH has emerged as the leader in asthma prevention and treatment in Imperial County. They were key to coordinating and expanding existing asthma management efforts across sectors and led the establishment of multi-sector and multi-domain strategies and activities, including the Asthma Community Linkages Project. This work has resulted in a 20% reduction in asthma-related emergency department visits. Their focus on sustainable policy and systems change has transformed care delivery, expanded clinical-community linkages and shifted care upstream. During COVID-19, they also provided substantial monetary assistance to the Imperial Valley Community through COVID-19 Emergency Response Funding Plans.

Primary Organizational Partners: LHA Commission, San Diego State University Rise Center, PCPs, schools, care coordinators, CBOs, California Health & Wellness/County Agreement, El Centro Regional Medical Center, Comite Civico del Valle, Pioneers Memorial Healthcare District. Imperial County Office of Education, IV Business Recovery taskforce and Imperial Valley Equity & Justice Coalition.

Key Strengths/Assets as Identified by ACH: Ability to foster new dynamic partnerships, strong relationships with schools, focus on data and outcome tracking, ability to engage in policy change work, effectively leveraged the ACH model to expand POI focus.

Sustainability Plan: ACH leadership will likely transition to San Diego State University Rise Center, which is an existing partner. SDSU Imperial Valley leaders, faculty, and students will leverage existing community connections to address regional issues, center diversity, equity, and inclusion in all activities, and align efforts with state initiatives.

All in for Health - Merced County/Health Leadership Council

Backbone Organization: Merced County Public Health Department (public health department)

Geography: Merced County

CACHI Target Condition: Health Equity, Diabetes, Emotional/Behavioral Health

Strategies: Policy leadership, health workforce development

AIFH/HLC Role as Reflected in Backbone Interviews and Final Report Materials: The Health Leadership Council is a leader in Merced County's care landscape in both policy development and community-care linkages. Their focus has pivoted/expanded to workforce development since their inception.

Primary Organizational Partners: Central CA Alliance for Health, Dignity Health Mercy Medical Centers - Merced, Livingston Community Health, Merced County Behavioral Health and Recovery Services, Merced County Office of Education, Merced County Office of Education, Merced County Workforce Investment Commission, Emanuel Medical Center, Castle Family Health Centers, Golden Valley Health Centers, Merced County Human Services Agency, local school district, Merced County Public Health Department, Valley Children's Health Care, elected officials, community residents, and private providers.

Key Strengths/Assets as Identified by ACH: Consistent focus on data and outcome tracking, established as a community leader, effectively engaged business sector, improves health care provider collaboration, removes duplication of efforts and increases efficiency, built equity focus into bylaws.

Reinvent South Stockton Coalition

Backbone Organization: Reinvent South Stockton Coalition (Nonprofit Organization)

Geography: South Stockton

CACHI Target Condition: Trauma

Strategies: Violence prevention; education; workforce development; resident leadership; neighborhood transformation

RSSC Role as Reflected in Backbone Interviews and Final Report Materials: RSSC is a collective impact initiative that brings together and empowers residents to engage in and transform their communities and address the root causes of poverty and trauma, particularly in a historically underinvested area of the city that RSSC termed the South Stockton Promise Zone. Their objectives and strategies are shaped by a wide range of agency partners and residents. Working across focus areas, from improving parks to early childhood education to housing development, RSSC takes a holistic approach to addressing trauma and health at the community scale. This broad focus allows RSSC to align partners across previously disparate sectors and reimagine working relationships between agencies and residents in South Stockton.

Primary Organizational Partners: RSSC is a collaboration of over 60 partners from the health, education, public safety, workforce development, and neighborhood revitalization sectors. Partners are split up into eight different result areas, with some overlap. The lead partners for each result area are San Joaquin County Office of Education, Stockton Service Corps, Stockton Unified School District, Stockton Scholars, Office of the Mayor of Stockton, Stockton Police Department, Healthier Community Coalition, SJC Transforming Communities for Healing, and San Joaquin Council of Governments. The Steering Committee is composed of partners from Visionary Home Builders of CA, Dignity Health, St. Joseph's Medical Center, EdTrust

West, San Joaquin County Public Health Services, HealthForce Partners, Little Manila Rising, Third City Coalition, Edible School Yards, and Stocktonians Taking Action to Neutralize Drugs (STAND).

Key Strengths/Assets as Identified by ACH: BB has gained community trust and has remained stable through political transition, focus on systems change solutions for trauma services and trauma-informed care, priorities are shaped by resident feedback, provides stipends to residents, strong focus on trainings, established wellness fund, and effectively integrated systems across sectors.

San Diego Accountable Community for Health

Backbone Organization: Be There San Diego (Nonprofit Organization)

Geography: San Diego County; North Inland San Diego

CACHI Target Condition: Cardiovascular Disease

Strategies: Nutrition services; care coordination system; ACEs programs

SD ACH Role as Reflected in Backbone Interviews and Final Report Materials: SD ACH is a data-driven collaborative that straddles two geographies and has cemented itself as an innovative and trusted community leader through pioneering racial justice and equity conversations and trainings among care networks, effectively leveraging funding to fund community-driven efforts, and maintaining focus on root causes and upstream solutions to address cardiovascular disease and nutrition security and improve the care landscape overall. Their efforts are guided by diverse community input and their Neighborhood Networks program facilitates funding flowing into the community through CBOs and improved health outcomes, such as a recent vaccination campaign that gave over one thousand vaccinations.

Primary Organizational Partners: Over 50 partners from various sectors involved in ACEs Network of Care Learning Collaborative which SD ACH launched including foster system, justice system, healthcare and health technology, early childhood education, residents with lived experience, and more. Key partners listed in POI are San Diego Food Bank, Feeding America, Vista Community Clinic, TrueCare, Neighborhood Healthcare, Fallbrook Family Health Center, Leah's Pantry, North County Food Policy Council, American Heart Association, County of San Diego/Live Well San Diego, 2-1-1 San Diego, and Jewish Family Service.

Key Strengths/Assets as Identified by ACH: Broadened partners' reach through network building and bringing them into the Medicaid Managed Care community health network, established Neighborhood Networks program which facilitates contracting with CBOs and thus funds community driven efforts, effectively disrupts silos (particularly through facilitating communication and collaboration between medical providers, care plans, and CBOs who were not in contact before), strong quantitative data focus and commitment to metrics tracking including publishing public Data Dashboard on their website, piloting programs on small geographic scales before scaling them up, backbone organization is organized and future-thinking.

West Sacramento ACH Initiative

Backbone Organization: Health Education Council (nonprofit)

Geography: West Sacramento

CACHI Target Condition: Heart disease among low-income communities

Strategies: Increase access to healthy food, increase walkability, increase community connection, collaboration with residents

W-SACHI Role as Reflected in Backbone Interviews and Final Report Materials: W-SACHI works in collaboration with resident stakeholders to find real, community-based solutions to the epidemic of cardiovascular disease in West Sacramento's low income communities. By focusing upstream on root causes such as education, housing, food access, and social connectedness, they are able to influence and improve long-term health outcomes. W-SACHI utilizes the resources of their multi-sector coalition, putting residents and health providers at the same table to maximize impact.

Primary Organizational Partners: Sutter Health, CommuniCare, Yolo Food Bank, West Sacramento Urban Farm Program, HEC, Center for Land Based Learning, Yolo Health and Human Services, Yolo County Children's Alliance, Partnership Health Plan, Bryte and Broderick Community Action Network, Iris Health Medical Group, Yolo Community Foundation, Mercy Coalition of West Sacramento, River City Medical Group, International Rescue Committee, Washington Unified School District, City of West Sacramento, Kaiser Permanente, and Elica Health Centers.

Key Strengths/Assets as Identified by ACH: Strong resident engagement strategy, develops strategy in response to resident input, focuses on underinvested areas of the city, focuses on "seamless" service delivery through partners coordinating efforts (e.g. pop-up vaccine clinics at food bank distribution sites), increased resource flow to low-income neighborhoods, maintained equity as a core value throughout ACH work.

Appendix 4: ACH Accomplishments in the Last Grant Year and Over the Course of

ACH	Top Accomplishments in Last Grant Year	Top Accomplishments Over the Course of CACHI
Boyle Heights	» Childhood Trauma Steering Committee » Pilot Program with the Pediatric Clinic at the LAC+USC Medical Center » Collaboration with other ACHs (Specifically MOU with San Diego to explore options to contract with MCOs)	» Built a focus-driven collaborative of public, private, and community partners reflective of community needs. Built community leadership and capacity » Informed development projects in and around LAC+USC Medical Center and USC Health Sciences Campus » Identified and shaped policy recommendations impacting eastside communities » Was a strong and credible advocate for community interests. Secured community benefits for current and future residents (e.g., local hire, affordable housing, health services, etc.)
East San Jose	» Fundraising and fund distribution efforts during the first year of the pandemic » The development of our ACH's finance and sustainability strategy » Our effort to enhance clinic to community linkages related to IPV screening and education	» Established a Wellness Fund » Undertook the Results-Based Accountability planning process » Engaged in the recruitment, retainment, and leadership development of our resident members
Fresno	» Fresno County ACEs Aware Trauma Informed Network of Care - February 1, 2021 – February 28, 2022 » 40 organizations were onboarded and trained in ACEs science and toxic stress	» Used the FCHIP Trauma and Resilience Network (TRN) workgroup as a central guiding force in all FCHIP's work. Now trauma-informed practices are at the root of every project FCHIP takes on or collaborates in.

Appendix 4: ACH Accomplishments in the Last Grant Year and Over the Course of CACHI *(Continued)*

Fresno	» 35 organizations were trained to use the referral platform FindHelp.org » Three community health workers (CHWs) hired and trained » 100 Medi-Cal healthcare providers across five health systems conducted ACEs screenings - September 1, 2021 – March 28, 2022 » 216 referrals have been made with 91 closed-loops referrals » Youth Leadership Council — comprised of a diverse group of 14 students who are juniors or seniors in high school or freshmen in college from the Fresno Unified Schools Doctors Academy. They are offered various workforce development components and a platform to learn from and converse with local community health and medical experts » Fresno HOPE — A Pathways Community HUB (PCH) supports seven contracted Care Coordination Agencies and more than 25 Care Coordinators/CHWs to build capacity and work together to address health disparities. Using the PCH model, CHWs offer families the opportunity to be decision-makers in their own health outcomes by guiding them through identifying risks and connecting them the appropriate social, mental health, and medical services resources to remove barriers to health.	Conducted a Community Health Needs Assessment (CHNA) that engaged with 480 community residents, diverse populations, stakeholders, and key informants from February to December 2019. The CHNA reached underserved and vulnerable populations to understand their needs, develop priority areas of focus for the region, and establish the foundation for future planning. » Included diverse voices in the CHNA that have been most affected by COVID-19 disparities as a precursor to integrating a diversity, equity and inclusion (DEI) lens and authentic community engagement practice in all elements of FCHIP's work and partnerships

Appendix 4: ACH Accomplishments in the Last Grant Year and Over the Course of CACHI *(Continued)*

Humboldt	» HCHT recognized as a central coordinating and convening table that can triage community issues and work on system-level strategies. » Established the Humboldt County Drug Medi-Cal Huddle following the launch of Partnership Health Plan's Wellness and Recovery Regional model » Launched North Coast Care Connect-Humboldt County's Community Information Exchange. After four years of research, discovery, financing, co-design, and partner engagement, the North Coast Care Connect went live on February 1st, 2022	» Launched North Coast Care Connect » Launched Humboldt County Drug Medical Huddle » Engaged in Comprehensive System Discovery Efforts through a series of key informant interviews with service providers and 10 community listening sessions. This, along with cross sector data exchange work piloted by NCHIIN and DHHS, became an early impetus to improve coordination and referral management across the system, which eventually evolved into CIE work.
Imperial	» Hosted the first ever local non-profit training, which focused on capacity building and sparked the formation of effective partnerships » Provided over $1.6 million in targeted COVID-19 support to the non-profit, healthcare, business, and public health sectors through the utilization of Wellness Fund dollars » Engaged new and existing partners through the Community Health Assessment and Community Health Improvement Plan	» Improved the continuity of care through the Asthma Community Linkages Project and significantly reduced asthma-related ED admissions » Expanded POI across several focus areas and enabled the extension of the ACH model to address other community issues » Achieved strategic alignment which led to an expansion of the multi-sector collaborative

Appendix 4: ACH Accomplishments in the Last Grant Year and Over the Course of CACHI *(Continued)*

Lake	» Shifted focus to be the convener and facilitator of the CHNA and CHIP » Developed a sustainable braided funding model through the CHNA/CHIP role » Established relationships with resident leaders and organizations	» Hope Rising formed, governance structure established, and collaboration achieved » Established the Hope Center with 20 transitional housing beds » Modernized the county's approach to data through the first CHNA that Hope Rising hosted in 2018/19
Long Beach	» Establishing a mutual aid network amongst the Steering Committee in 2020 » Development of the first iteration of the Portfolio of Interventions (POI) » Development of a 5-year POI	» Created a POI. » Retained consistent membership over the last five years » Influenced other agencies and collaboratives that are a part of the Steering Committee to alter how they conduct business
Merced	» Pre-existing ACH infrastructure assisted in COVID-19 responses: The foundation of the Health Leadership Council helped the COVID-19 response » Relaunching of multi-sector council: An additional top accomplishment was during the last year of the grant, included re-launching the Health Leadership Council to a broader focus » Expansion and continuous engagement of outreach taskforce for countywide coordination	» Expanded the stakeholder group to include diverse partners. » Remained flexible and persevered through countless hurdles, leadership changes, directional pivots, and a global pandemic » Adapted interventions to meet the needs of community (e.g., away from diabetes prevention, towards COVID testing)

Appendix 4: ACH Accomplishments in the Last Grant Year and Over the Course of CACHI *(Continued)*

San Diego	» Revised contracts with Medi-Cal managed care health plans, modified billing procedures, purchased a new online technology care management platform, and retrained staff from all community-based organization partners. Neighborhood Networks launched two additional projects: 1) a pediatric quality project, which co-locates a community health worker in a pediatric office for the purpose of improving HEDIS measures for well child visits and assisting families with high ACEs scores, and 2) a COVID-19 community outreach project » Launched the ACEs Network of Care Learning Collaborative - convened over 50 partners from a variety of sectors. ACEs Aware funding also supported creation of two practice papers: » How Accountable Communities for Health Can Lead Multi-Sector Partnerships to Address the Effects of Adverse Childhood Experiences » Community Information Exchange	» Established Neighborhood Networks. » Changed the governance structure. A seat on the SDWC board of directors was created for the SDACH Stewardship Group chairperson, so SDACH concerns and activities can be brought to the board for consideration. » Created a POI and implemented Results-Based Accountability (RBA). » The Jacobs & Cushman San Diego Food Bank's Feeding Everyone with Equity and Dignity (FEED) program modernized and streamlined the collection of data from recipients, eliminating registration redundancies and drastically reducing wait times. Clients are issued a simple, personalized food ID card that they can use at multiple San Diego Food Bank sites without having to provide basic household information or complete duplicate paperwork. » Seven organizations participated in a trauma-informed nutrition learning collaborative and implemented trauma-informed principles and practices within their organizations. » Trauma-informed nutrition trainings took place for clinical staff at a local FQHC.
San Gabriel Valley	» Growth and development of All in for Azusa (AIFA) prototype — working groups include: » Integrated Care (working on two interventions focused on youth and seniors) » Community Engagement and Diversity (a newly formed group focused on community engagement and equity)	» Continuously engaged strong regional and local relationships. HSGV has continuously nurtured regional partnerships for more than ten years, including hosting an annual conference, Roadmaps and Intersection.

Appendix 4: ACH Accomplishments in the Last Grant Year and Over the Course of CACHI *(Continued)*

San Gabriel Valley	» Workforce Development (focused on creating educational pathways for employment through local community colleges and resources for job development) » Coordinating Council (a monthly networking opportunity for sharing resources) » Launching officially in May » Secured federal funding for the Azusa Teen and Family Center - Partners united around a strong proposal and the submission was included in a House bill that passed. The $560,000 funding request was secured on March 9, 2022. » Completed a network analysis of the social connectedness between partners in AIFA and HSGV — to visualize the network relationships, provide insights about the ways they work together, identify opportunities for continued network development, and demonstrate the impact of their collective efforts to funders and stakeholders.	» Continuously engaged strong regional and local relationships. HSGV has continuously nurtured regional partnerships for more than ten years, including hosting an annual conference, Roadmaps and Intersection. We have been able to link individual entity goals to the goals of the collaborative, which has facilitated a better understanding of the need for how integrated strategies across multiple sectors contribute to overall health and wellbeing. » Ensured a strong backbone and central coordinating agency. The YWCA-SGV is a large and well-respected regional and local partner. » Secured ongoing funding from a local foundation as well as other key partners. We have garnered $810,000, of which $120,000 is in-kind.
Sonoma	» Redesign and Launch of Health Action 2.0 » Operationalizing Racial Equity as Core Value » Hearts of Sonoma County Transition to Community Partner Backbone	» Established a cardiovascular Portfolio of Interventions » Focused on racial equity. Identified equity-focused systems change as the core work of Health Action 2.0 as a collaborative action network » Wellness Fund Journey led to Health Action Transformation

Appendix 4: ACH Accomplishments in the Last Grant Year and Over the Course of CACHI *(Continued)*

Stockton / RSSC	» Bringing Trauma Transformed to South Stockton » Launching the Parks Activation & Beautification initiative and driving community and City engagement with Williams Brotherhood Park, the only park of significant size serving 50,000 residents in South East Stockton » Launching the Stockton Housing Justice Coalition (HJC), leading to the establishment of the Stockton Housing Innovation Fund	» Built a stable, trusted backbone organization focused on the needs of South Stockton. » Moved many more community-serving systems toward delivering trauma-informed care and increased behavioral health treatment resources. » Connected the needs of and solutions generated by the most marginalized communities to health care organizations and systems.
West Sacramento	» Aligned resources leading to increased dissemination of food and COVID resources including: COVID testing/ vaccination; produce through mobile markets and food deliveries through a partnership with the West Sacramento Housing Development Corporation. » Partnered with the City of West Sacramento to obtain approximately $10,000,000 for park/recreation improvements. » Kaiser Permanente provided financial support via the Health Education Council (HEC) to serve as convener of a variety of health and social services providers to create a community network to connect residents to health and social care needs via UniteUs in Yolo County building on the ACH infrastructure and partnerships	» Educated City Council members leading to a city-wide flavored tobacco ban and expanded relationship with local government leading to planning for a city racial equity policy. » Launched a coordinated response to increase access to COVID resources and healthy food. » Increased financial resources for targeted neighborhoods and identified resident priorities including approximately $10,000,000 for park/ recreation improvements.

Appendix 5: CACHI 5-Year Milestones Associated with Developing an ACH

INTRODUCTION

The California Accountable Communities for Health Initiative (CACHI) has two primary goals for Accountable Communities for Health (ACH): 1) create an enduring platform, with attention to the seven core elements, for addressing population health issues of concern to communities, and 2) demonstrate the success of the ACH approach for the chosen health condition, with evidence of progress toward improved health outcomes and cost moderation/avoidance.

By design, CACHI is a systems-change initiative that seeks to move from "business as usual" to a more collective approach for addressing population health issues in communities. This requires a culture change and shift in mindset among partners to embrace the notion that no one organization or sector can "do it all" when it comes to addressing complex health and social issues challenging communities.

The milestones—along with the outcomes and indicators described below—seek to chart the progress of implementation and articulate key steps and accomplishments at various intervals over the course of five years, the time frame that we believe is needed to develop a fully operational ACH. For example, Year One milestones emphasize the start-up nature of the ACH, with a focus on infrastructure, relationship building, and resident engagement. Years Two and Three focus on solidifying the infrastructure, including setting up the Wellness Fund, obtaining agreement on outcomes and measures, and finalizing the development of a comprehensive portfolio of interventions and sustainability plan. Years Four and Five represent a maturation of the ACH, including securing resources and operationalizing the Wellness Fund and filling in identified gaps of the portfolio of interventions. Bringing an equity lens to the ACH is critical to its success and should be integrated throughout the developmental process. Altogether, these changes represent a new way of interacting among the various partners and residents resulting in a collective effort to improve the health of the community.

It's important to recognize that creating an ACH is an iterative process. Depending on the history and assets of a given community when it embarks on this effort, progress may be quicker on some elements, while others may take more time. Moreover, the ultimate structure of the ACH will depend on how it builds on, links, or aligns with existing initiatives or collaboratives within each community. Flexibility should be used in applying and interpreting progress on the individual milestones.

The Milestones are organized as follows:

- Each of the five milestones is described with a goal statement.
- Under the goal statement are a limited number of outcomes (a, b, c, etc.).
- Under each of those outcomes are the specific ways, or indicators, that demonstrate that the milestone is being met. The indicators are crafted to provide communities flexibility for how they are met; for the most part, specific processes are not prescribed.

1. SOLIDIFY ACH INFRASTRUCTURE AND ITS RELATIONSHIPS TO OTHER INITIATIVES AND/OR COLLABORATIVES

a. The ACH has developed a shared long-term vision, which prioritizes population health improvement, developed through a collaborative process that engages the community.

YEAR ONE

- The ACH formally adopts a shared vision, and a set of near-term goals related to the development of the ACH, based on input from ACH partners

YEAR TWO

- The ACH partners have a clear understanding of how the ACH (or its activities) fits and/or integrates with other collective action tables or structures.

YEAR THREE

- The ACH annually reviews the vision and goals to update short-term, medium-term and long-term goals and ensures that equity is explicitly articulated as a core principle and priority.

YEAR FOUR

- ACH partners align their priorities with the vision and goals of the ACH and begin to align with community priorities.

YEAR FIVE

- The ACH refreshes its vision to incorporate new priorities and conditions.

b. The ACH has identified a trusted well-respected backbone entity with the trust and capacity to convene and coordinate the various aspects of the ACH.

YEAR ONE

- The backbone entity hires staff, preferably with at least 50 percent time project director or manager dedicated to the ACH.

YEAR TWO

- Roles and responsibilities of the backbone entity are clearly defined and, to the extent some of the roles are carried out by other organizations, they are made explicit.

YEAR THREE/FOUR

- The ACH periodically reviews how the backbone functions are being carried out and confirms the existing backbone entity or chooses a new backbone entity(ies) to carry out those activities.

YEAR FIVE

- The ACH has secured funding, either directly, in-kind, or through the Wellness Fund, to support the backbone's core functions and ongoing operations.

c. The ACH has established a sound governance structure, including a leadership team that includes residents, which ensures effective decision-making and accountability to partners and the community, and is developing a high level of trust among members.

YEAR ONE

- The ACH establishes a leadership team to include backbone, partner organizations and residents. Organizational members are decision-makers who can commit their organizations (or obtain such a commitment) to agreed-upon strategies. Ideally, each member organization completes a participation agreement.
- The ACH makes progress toward establishing a formal governance structure and creates sub-committees as appropriate (e.g., sustainability and financing, resident engagement).

YEAR TWO

- The leadership team subscribes to a distributed leadership model with various team members assuming leadership roles on different topics such as sustainability, particular interventions within the portfolio, etc.
- The ACH finalizes a formalized governance structure and processes to: monitor activities, secure and/or renew member commitments, manage member turnover and changes, document decision-making responsibilities and conflict resolution processes, and identify course corrections, as appropriate to achieve goals.

YEAR THREE

- The ACH establishes mechanisms and practices of transparency to ensure accountability between partners and between the leadership team and the community.

YEAR FOUR

- The ACH establishes regular opportunities to report to and gather input via town hall or other open community sessions.
- The ACH assesses and updates the process for onboarding new partners and resident leaders based on the experiences and evolution of the ACH.

YEAR FIVE

- The ACH reviews and revises the governance structure and work groups as it takes on new priorities.
- The ACH adopts a systems-change orientation to its work and its practices reflect transformed norms, mindsets, and ways of working together.

d. The ACH includes a diverse set of partners and organizational leadership from clinical, community health, social services, education, grass roots and consumer organizations, residents, and other stakeholders relevant to the selected health issue.

YEAR ONE

- The ACH includes partners, from the health and health care sectors and other non-health sectors, aligned with the selected condition (e.g., education, justice, social sectors).
- The ACH establishes a leadership team and a broad "all-partners" group of stakeholders.

YEAR TWO

- There is a high level of participation by senior-level people of partner organizations

YEAR THREE

- There is a continued high level of participation by senior level people of partner organizations representing a range of sectors and entities.
- Relationships and trust between partners deepen.
- Partners exhibit a commitment to collaboration over competition.

YEAR FOUR

- The ACH reviews partner composition in light of new health priorities (see POI below).
- ACH partners begin to change their practices to better align and collaborate with each other.

YEAR FIVE

- New partners join the ACH to reflect the new priority or condition.

2. EMBED EQUITY AS A CORE PRINCIPLE THROUGHOUT ACH POLICIES AND PRACTICES AND INSTITUTE MEANINGFUL COMMUNITY OUTREACH AND ENGAGEMENT STRATEGIES

a. The ACH adopts and incorporates equity, diversity and inclusion principles throughout the activities of the ACH.

YEAR ONE

- The vision and goals explicitly articulate a commitment to equity and identifies steps to operationalize equity as a core value.

YEAR TWO

- The ACH practices equity, diversity, and inclusion in its decision making-processes and attends to power dynamics.
- The ACH explicitly incorporates equity-based criteria for developing outcomes and indicators (e.g., targets are tied to racial/SES outcomes), portfolio interventions, data strategy, and Wellness Fund priorities.

YEAR THREE

- The ACH reviews and assesses how and the degree to which its governance processes have incorporated principles of equity, diversity, and inclusion.

YEAR FOUR

- The ACH identifies data sources and methods that can identify potential health disparities, and a narrative that demonstrate how its activities advance equity.
- The ACH uses advancing equity and diversity as explicit criteria in considerations for expanding to new geographies or addressing additional health conditions.

YEAR FIVE

- The ACH incorporates equity considerations as key criteria for measuring success in terms of its own operations as well as the implementation of the portfolio of interventions.

- The ACH demonstrates specific ways in which it is operating more equitably and inclusively (e.g. diverse resident engagement on the leadership team and involvement with interventions, more equitable distribution of resources, greater attention to communities and populations with health disparities, implementing interventions to specifically address health inequities, etc.).

b. The ACH engages residents and the community-at-large in the governance of the ACH, as well as the design and implementation of interventions.

YEAR ONE

- The ACH includes residents from the target geography in all aspects and levels of its structure (e.g. leadership team, work groups, all-partners groups). Resident leaders are supported to participate (training, stipends).

YEAR TWO

- The ACH establishes processes for regularly communicating with and meaningfully engaging residents within the target geography about the portfolio of interventions and other aspects of the ACH.
- Residents actively participate in the ACH, especially in decision-making processes, to help set priorities and goals.

YEAR THREE:

- Residents and representative CBOs are trained and understand how to use data and narratives produced by the ACH to spread the word about the ACH's accomplishments.
- Residents and representative community-based organizations from targeted communities are engaged in a decision-making capacity at multiple levels in the ACH and actively shape the priorities and implementation of interventions.
- Residents are engaged and involved in carrying out interventions (not just being the subject of them), ideally assuming leadership of one or more interventions. For example, churches may conduct a blood pressure screening, local residents may beautify area parks, etc.

YEAR FOUR

- The ACH demonstrates accountability to the community, and community champions understand and support the goals of the ACH.

- ACH incorporates multiple strategies to maximize resident involvement (e.g., meetings in community locations, after hours, language accommodation).

YEAR FIVE

- Priorities for ACH activities and outcomes are aligned with needs and expectations of the community and a process for consistently soliciting and incorporating community priorities is in place.

3. DEVELOP, IMPLEMENT, AND REFINE A COHERENT PORTFOLIO OF INTERVENTIONS WITH SIGNIFICANT REACH AND STRENGTH

a. Interventions are aligned across the five domains to achieve a set of prioritized outcomes that address varying stages of the selected issue and include short to long-term timeframes, upstream and downstream factors, and measures for monitoring success.

YEAR ONE

- The ACH utilizes the Community Health Needs Assessments and other community inputs to determine a priority health issue or community condition, and in considering an initial portfolio.
- The ACH collectively develops an understanding of the root causes of the health issue or community condition, including any relevant policies or systems barriers that have led to racial, ethnic, or gender inequities associated with the issue or condition.
- The ACH inventories interventions that are already underway, identifying the relationship between the interventions and a set of common outcomes (note that multiple interventions should lead to such outcomes).

YEAR TWO

- The ACH develops a preliminary portfolio of interventions that includes all five domains and a mix of upstream and downstream (prevention and treatment) activities. Potential new interventions in the community-clinical linkages domain may be identified along with needed systems changes.
- The ACH identifies a select number of common and measurable outcomes for the portfolio and their respective indicators of success. (Note that because some outcomes may take years to manifest, short or medium-term process or interim outcomes may also be identified.)

- The ACH identifies gaps in interventions, based upon ensuring a breadth of activities across the five domains, evidence, dose, reach, cost, near/intermediate/long term benefits, etc., and potential strategies for addressing them.
- The ACH creates an implementation plan for interventions across all five domains.

YEAR THREE

- The ACH aligns interventions in all five domains toward a common set of outcomes.
- The ACH develops a plan to address gaps in the portfolio that prioritizes interventions that 1) address gaps with regard to composition and reach 2) are prevention oriented, and 3) advance health equity. (Plans to address gaps may take the form of capacity expansion to meet community needs within an existing intervention; new interventions identified as high priority to achieve the outcomes; or longer-term prevention or environmental change (upstream) interventions not yet addressed.)
- The ACH establishes a practice to annually monitor implementation of the plan.

YEAR FOUR

- The ACH incorporates a quality improvement approach to improve interventions.
- The ACH reviews the portfolio of interventions to assess the degree to which interventions are mutually reinforcing and aligned toward a common set of outcomes.
- Upon reviewing the progress of the implementation plan, the ACH refines the Portfolio as needed, with particular attention to long-term prevention-oriented aspects of the portfolio.

YEAR FIVE

- The ACH reviews the portfolio of interventions for progress toward advancing a common set of outcomes and refines the portfolio as needed, with particular attention to overall balance of short-term and long-term, breadth and depth, upstream and downstream.

b. The ACH team adopts new goals and next steps for the portfolio, which may include increased funding for existing interventions, expansion beyond the current target geography or adopting a new community health priority.

YEARS ONE, TWO, & THREE: NA

YEAR FOUR

- An ACH planning team is convened and develops a series of strategic options for the next phase of ACH implementation, including identifying a new health issue.

YEAR FIVE

- The ACH begins planning for the development of a portfolio of interventions for new health, geographic or population priorities with a continued focus on upstream interventions, prevention and health equity.

4. DEVELOP AND IMPLEMENT THE ACH'S SUSTAINABILITY APPROACH/PLAN, INCLUDING SECURING FUNDING SOURCES, AND ESTABLISHING A WELLNESS FUND

a. The ACH has adopted and is implementing a sustainability approach/plan that articulates its value, quantifies its needs, and identifies specific funding sources.

YEAR ONE

- The ACH identifies a team made up of individuals from various partners to lead its work on sustainability and financing, e.g., through a designated workgroup.

YEAR TWO

- The ACH begins development of a sustainability plan, starting with a statement of benefit and value, e.g., a value proposition. The value proposition should identify both financial and non-financial benefits of an ACH.
- The ACH determines the level of funding needed to support the backbone entity on an ongoing basis.

YEAR THREE

- The ACH determines "best guess" estimates for levels of funding needed to support identified gaps associated with implementing the portfolio of interventions, at sufficient reach and strength.
- The ACH finalizes a sustainability plan and approach that includes agreements among partners regarding sustainability strategies and begins implementation.

YEAR FOUR

- The ACH captures and reports financial and non-financial value through both quantitative data and narrative, related to Years One and Two activities to stakeholders.
- The ACH develops a funding appeal for the ACH and key activities associated with the Portfolio of Interventions and obtains commitments from more than one funding source.
- ACH partners collaboratively seek funding and competition is reduced.
- ACH partners demonstrate commitment to the sustainability of the ACH through funding and in-kind contributions.

YEAR FIVE

- The ACH pursues long-term and sustainable financing mechanisms.
- The ACH develops a funding strategy for the new health condition.

b. The ACH operates a Wellness Fund as a vehicle for attracting, braiding, and blending resources from a variety of organizations and sectors, to support the ACH's infrastructure and activities in alignment with the goals, priorities and strategies developed by the ACH.

YEAR ONE

- ACH develops goals and principles for a Wellness Fund
- ACH begins a planning process for a Wellness Fund.

Y*EAR TWO*

- ACH identifies options for a Wellness Fund administrator, which include potential strengths and gaps in needed capacities; capacities include the ability to carry out the various financing strategies identified in the sustainability plan/approach (e.g., blend and/or braid resources) as well as to monitor and report funding received and expenditures.

YEAR THREE

- The ACH formally selects an administrator for the Wellness Fund, formalizes a governance structure to oversee it, and develops written agreements that outline accountability and decision-making roles between the two entities.
- The Fund develops a plan to address any critical gaps in capacities identified above.

- The ACH and Wellness Fund collaboratively establish the fund disbursement/grantmaking framework and criteria.

YEAR FOUR

- The ACH secures resources to support one or more gaps in the Portfolio of Interventions, such as scaling and spreading existing interventions, start-up of critical new interventions, etc. or address a common priority of the ACH.

YEAR FIVE

- The ACH secures contributions from diverse sources.
- The ACH prioritizes allocating funding that supports upstream interventions and prevention, and advances health equity.

5. IMPLEMENT NEW AND IMPROVED CURRENT CAPACITIES TO COLLECT DATA, SYNTHESIZE, AND SHARE DATA AMONG PARTNER ORGANIZATIONS, AND COMMUNICATE TRANSPARENTLY TO COMMUNITIES AND STAKEHOLDERS ON THE PROGRESS OF THE ACH, ITS INTERVENTIONS, AND MILESTONES.

a. The ACH identifies, collects, and/or synthesizes, and reports data to monitor and communicate through a dashboard progress regarding ACH assets and infrastructure (e.g., Wellness Fund), outcomes (e.g., selected health condition) and overall impact.

YEAR ONE

- The ACH inventories available data sources related to the priority health issue or condition.

YEAR TWO

- The ACH identifies outcome measures and indicators of success that reflect its priority health issue or condition and Portfolio of Interventions.
- The ACH determines how it will monitor progress on all selected outcome measures and indicators of success, including identifying data sources, frequency of data availability, and whether data sharing agreements are needed, etc.
- The ACH identifies indicators for which data are unavailable, but desired, and plans for how data can be collected.

YEAR THREE

- The ACH operationalizes all selected outcome measures and indicators of success and begins regularly reporting on the measures.
- The ACH determines its audiences for internal and public facing reporting and identifies which outcome measures and indicators of success should be reported to which audience, and with what frequency and through what format.

YEAR FOUR

- The ACH expands its regular reporting to include any outcome measures or indicators of success not reported previously.
- The ACH identifies needed infrastructure, analytical capacity, and processes for routine data reporting to support quality improvement and monitoring needs, including any necessary staff development, technology acquisitions, or funding.

YEAR FIVE

- The ACH has the infrastructure, analytical capacity, and processes in place for routine data reporting to support the quality improvement and monitoring needs of ACH activities, including the Portfolio of Interventions and Wellness Fund investments.

b. The ACH implements communication strategies, using data and accessible, visual mechanisms, to "tell its story."

YEAR ONE: *N/A*

YEAR TWO

- The ACH develops a preliminary narrative and overall communications approach to explain the ACH to partners, potential partners and other key audiences, including, ultimately, the community.

YEAR THREE

- The ACH adopts a narrative template to tell the story of its value to multiple audiences, including the community, using data, visuals and a narrative story.
- The ACH finalizes a communication plan that identifies selected audiences, key messages, interventions and activities to highlight, and communications medium(s) that it will implement.

- The ACH begins implementing components of its communications plan, including prioritizing audiences, developing key materials (e.g., presentations, webpages, etc.), and conducting outreach.

YEAR FOUR

- The ACH continues to implement its communication plan.
- The ACH uses data visualization approaches, including dashboards, to increase transparency and communicate accountability to partners, investors, and the community.

YEAR FIVE

- The ACH refines its communications strategy to incorporate storytelling, data visualization approaches, and audience-specific messages, to convey progress on indicators and documenting systems changes.

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